Supreme Court, U.S.
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No.

IN THE

Supreme Court of the United States

LOUISIANA HEALTH SERVICE & INDEMNITY CO., doing business as Blue Cross and Blue Shield of Louisiana,
Petitioner,

v.

RAPIDES HEALTHCARE SYSTEM; STATE OF LOUISIANA; CHARLES R. FOTI, JR., Attorney General for the State of Louisiana; DAUTERIVE HOSPITAL,
Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Whether the Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001, *et seq.* ("ERISA"), preempts a state law that purports to override lawful ERISA plan terms that prohibit the assignment of benefit claims, because the state law relates to ERISA plans within the meaning of ERISA Section 514(a), 29 U.S.C. § 1144.

2. Whether ERISA preempts a state law that authorizes an action to collect benefits previously paid to a plan participant and establishes a remedy outside ERISA's exclusive civil enforcement scheme, because the state law conflicts with the cause of action for benefits set forth in ERISA Section 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B).

LIST OF PARTIES TO THE PROCEEDING

The names of all parties to the proceeding in the United States Court of Appeals for the Fifth Circuit appear in the caption of the case on the cover page.

CORPORATE DISCLOSURE STATEMENT PURSUANT TO RULE 29.6

Pursuant to Supreme Court Rule 29.6, Petitioner states that it has no parent companies or non-wholly owned subsidiaries, and no publicly held company owns ten percent or more of Petitioner's stock.

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In the
Supreme Court of the United States

PETITION FOR A WRIT OF CERTIORARI

Petitioner Louisiana Health Service & Indemnity Co. (d/b/a Blue Cross and Blue Shield of Louisiana) ("Blue Cross") respectfully prays that a writ of certiorari issue to review the judgment of the United States Court of Appeals for the Fifth Circuit in this case.

OPINIONS BELOW

The opinion of the United States Court of Appeals for the Fifth Circuit is reported at 461 F.3d 529 (5th Cir. 2006) (App. A). The October 12, 2004, opinion and order of the United States District Court for the Middle District of Louisiana is unreported (App. B). The April 15, 2002, opinion and order of the United States District Court for the Middle District of Louisiana is reported at 213 F. Supp. 2d 650 (M.D. La. 2002) (App. C).

JURISDICTION

The district court had federal question jurisdiction over Blue Cross's claim pursuant to 28 U.S.C. § 1331 and 29 U.S.C. § 1132(e), insofar as an action asserted against a State, seeking a declaratory judgment of preemption, presents a federal question arising under the Employee Retirement Income Security Act of 1974, 29 U.S.C. §§1001, *et seq.* ("ERISA"). The court of appeals had jurisdiction to review the final judgment of the district court pursuant to 28 U.S.C. § 1291. The date on which the United States Court of Appeals for the Fifth Circuit decided this case was August 16, 2006. A timely petition for rehearing *en banc* was

denied by the Fifth Circuit on September 15, 2006 (App. D). Judgment was issued as mandate on September 25, 2006 (App. E). The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

The Supremacy Clause of the Constitution, U.S. Const., art. VI, cl.2, the pertinent provisions of ERISA, 29 U.S.C. §§ 1001, *et seq.*, and the Louisiana statute at issue, *La. Rev. Stat. Ann.* § 40:2010 (2001), are set forth in the Appendices, App. F, G, and H, respectively.

STATEMENT OF THE CASE

I. INTRODUCTORY STATEMENT

The Fifth Circuit's ruling that ERISA does not preempt a state assignment statute has created a split among the circuits and a conflict with decisions of this Court regarding the breadth of ERISA preemption – a recurring and contentious issue of great significance to employers, employees, health plans, and plan participants. Despite clearly expressed congressional intent that ERISA preempt the field of employee benefit plan regulation and enforcement,[1] the panel decision allows a State to mandate the inclusion in ERISA plans of particular contractual terms governing plan administration, and to establish a cause of action and remedy for ERISA benefit claims in addition to a payment to the plan participant.

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[1] *California Div. of Labor Stds. Enforcement v. Dillingham Constr., N.A., Inc.*, 519 U.S. 316, 336 (1997) (Scalia, J., concurring; Ginsburg, J., joining).

Even in decisions that ostensibly curtailed the reach of ERISA preemption, this Court reaffirmed that ERISA preempts any state law that purports to regulate the plan itself or conflicts with ERISA directly. Thus, ERISA necessarily preempts state laws that "mandate employee benefit structures or their administration," or provide "alternative enforcement mechanisms." *New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 658 (1995).

By prohibiting the inclusion of a lawful plan term barring assignment, *La. Rev. Stat. Ann.* § 40:2010 ("the Assignment Statute") mandates a particular benefit payment structure, and thus relates to ERISA. *See Egelhoff v. Egelhoff,* 532 U.S. 141, 148 (2001) (ERISA preempts state statute that requires administrators to pay benefits to beneficiaries chosen by state law, rather than to those identified in plan documents, because it runs counter to ERISA's command that fiduciaries administer plan in accordance with governing documents, and governs benefit payments, a central matter of plan administration). By establishing a state cause of action that potentially results in a double payment of benefits or a penalty, the Assignment Statute provides a conflicting, alternative enforcement mechanism. *Aetna Health Inc. v. Davila*, 542 U.S. 200, 209 (2004) (ERISA preempts state law that conflicts with ERISA's exclusive enforcement scheme by supplementing or supplanting ERISA claims or remedies). In a decision that arguably applies to all ERISA-governed plans, both insured and self-funded,[2] the Fifth Circuit here reached a result that is contrary to these ostensibly straightforward principles and conflicts with decisions of the Eighth and Tenth Circuits. Review by this Court will provide much

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[2] *See infra,* footnote 12.

needed clarity and guidance in an area of continued confusion in the lower courts.

II. FACTUAL BACKGROUND

Blue Cross underwrites, provides, or administers various forms of health benefits through individual, association, and employer health benefits plans. The most common form of group health plan offered is a "participating provider" plan that extends higher levels of benefits when members choose to obtain services from providers who are part of a designated network of providers. These participating provider plans benefit plan sponsors and participants by keeping premiums and out-of-pocket costs lower, and benefit providers by supplying a large pool of potential patients.

Contracts for group health insurance policies issued or administered by Blue Cross, including ERISA plans, provide that all benefits payable are personal to the plan member and are not assignable in whole or in part. (App. I). However, the plans may pay benefits directly to "participating providers" who have executed contracts for direct payment. Thus, these direct payment provisions permit the plans to pay benefits directly only to members or to participating providers. These are lawful ERISA plan terms, and ERISA obligates Blue Cross to pay benefits in accordance with those terms.

The Assignment Statute requires an entity that is obligated to pay medical benefits for hospital services to recognize any assignment to the hospital of an individual's right to those benefits. In pertinent part, the statute provides that if the payor-entity has notice of an assignment, payment to the individual plan participant will neither release that

entity from liability to the hospital, nor provide a defense to an action by the hospital to collect such benefits. (App. I).

Thus, if an ERISA plan acts in accordance with the Blue Cross direct payment provision and pays benefits directly to the individual plan participant, the Assignment Statute nevertheless requires the ERISA plan to pay the hospital – in effect requiring a double payment on a single liability. In the alternative, the Assignment Statute requires the ERISA plan to disregard the lawful ERISA plan provisions entirely, and pay benefits to the hospital, in violation of the controlling ERISA plan terms.

III. HISTORY OF PROCEEDINGS

Rapides Healthcare System submitted complaints to the Louisiana Department of Insurance ("DOI") alleging that various actions by Blue Cross violated state statutory provisions, including the Assignment Statute. In January 2001, the DOI Office of Health Insurance issued its determination, *inter alia,* that Blue Cross health insurance policies violate Louisiana law to the extent they prohibit members from assigning their benefits to hospitals.

Following the DOI determinations, Blue Cross filed a complaint pursuant to *Fed.R.Civ.P.* 57 and 28 U.S.C. §2201, seeking a declaratory judgment that ERISA preempts the provisions of *La. Rev. Stat. Ann.* § 40:2010 as applied to fully insured employee benefit plans governed by ERISA and insured or administered by Blue Cross, and that the DOI, the Attorney General, Rapides, or any other private party, is precluded from pursuing any action against Blue Cross to ensure compliance with its provisions. The District Court had subject matter jurisdiction pursuant to 28 U.S.C. §1331 and 29 U.S.C. §1132(e), insofar as an action asserted against

the State, seeking a declaratory judgment of preemption, presents a federal question arising under ERISA.[3]

On April 15, 2002, the District Court issued its Ruling denying Blue Cross's motion for summary judgment. The District Court determined that ERISA does not preempt the Assignment Statute because the statute is a "general health care regulation" not intended by Congress to be preempted, an assignment of benefits facilitates the employee's receipt of benefits, and the statute had at most only an indirect economic effect on ERISA plans. Further, the court held that ERISA's silence on the issue of assignability of welfare benefits "indicates that Congress intended to allow the states to make their own decisions regarding assignability." Ruling p.12 (App. C). In October 2004, the District Court reaffirmed its prior ruling. (App. B).

On August 16, 2006, the Fifth Circuit affirmed the District Court's decision. The panel concluded that the Assignment Statute is not "conflict preempted" as a law that conflicts with ERISA's exclusive enforcement mechanism because it does not impose any obligation on the ERISA plan administrator, nor create a separate or additional means of enforcement; the statute "merely passes the sole enforcement mechanism--ERISA § 502--from patient to hospital ...." 461 F.3d 529 at 535 (App. at 10a). The panel rejected Blue Cross's argument that the statute conflicts with ERISA by sanctioning a state law action "to collect benefits," and by establishing a remedy outside of ERISA by requiring a benefits payment to the hospital even if the plan has already paid benefits to the participant. The panel reasoned that if

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[3] *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96 n.14 (1983); *CIGNA Healthplan v. Louisiana ex rel. Ieyoub*, 82 F.3d 642 (5th Cir.), *cert. denied*, 519 U.S. 964 (1996).

Blue Cross complies with the Assignment Statute, it only pays the benefit once, and any "mistaken" payment to the participant could be remedied by seeking recovery of that payment from the person improperly paid. *Id.*, at 536 (App. at 11a).

The panel further determined that the statute is not expressly preempted under ERISA § 514 as a state law that "relates to" ERISA based on its reference to or connection with an ERISA plan.[4] The panel determined that the law does not "refer" to an ERISA plan because it applies neutrally to ERISA plans and other types of plans. *Id.,* at 536 (App. at 13a). The panel further determined that the Assignment Statute does not have an impermissible "connection with" ERISA plans, because by requiring a plan to recognize an assignment, the statute is merely enforcing the participant's choice to designate a hospital as a beneficiary.

The panel acknowledged that its decision created a split among the circuits. "We acknowledge that both the Eighth and Tenth Circuits have concluded that ERISA preempts similar assignment statutes." 461 F.3d at 539 (App. at 18a). The panel opined that to the extent the other circuits relied for their preemption findings on ERISA's silence regarding assignability, their reasoning was incorrect. Further, the panel held that this Court's rejection, beginning in *Travelers*, of an "uncritical literalism" in interpreting ERISA, required the panel to look to whether the state law "frustrated the federal interest in uniformity," and whether the state law was in an area of traditional state regulation.

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[4] "A law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan." *Shaw,* 463 U.S. at 96.

461 F.3d at 540 (App. at 19a). Considering these factors, the panel opined that the statute would have at most a minimal burden on plan administration, and a minimal impact on nationally uniform plan administration. 461 F.3d at 539 (App. at 18a).

Finally, considering the parties' opposing public policy arguments, the panel determined that nothing in ERISA required the court to alter the Louisiana legislature's decision to favor "assignment of benefit claims over inducing hospitals to enter into Blue Cross's provider networks." *Id.*, at 541 (App. at 21a).

REASONS FOR GRANTING THE PETITION

I. INTRODUCTORY STATEMENT

In its determination that ERISA does not preempt the Assignment Statute, the Fifth Circuit has created an irreconcilable conflict not only with decisions of other circuits and this Court, but with express congressional intent. This case presents an ideal opportunity for this Court to provide much needed guidance and clarity regarding the scope of ERISA preemption, specifically with respect to the power of a state legislature to mandate a particular manner of paying ERISA plan benefits, while establishing a state law cause of action and remedy for an ERISA benefits claim.

In enacting ERISA, Congress adopted the broadest federal preemption clause ever written, "[reserving] to Federal authority the sole power to regulate the field of employee benefit plans. With the preemption of the field, we round out the protection afforded participants by eliminating the threat of conflicting and inconsistent State and local

regulation."[5] By preempting the field, Congress "meant to establish employee benefit plan regulation as exclusively a federal concern."[6] The express statutory terms reflect this intent.

ERISA Section 514(a), 29 U.S.C. § 1144(a), provides that ERISA "shall supersede any and all State laws insofar as they ... relate to any employee benefit plan." Pursuant to this provision, state laws are "expressly preempted" if they refer to or have a connection with ERISA plans.[7] This provision reflects congressional intent to preempt entirely the field of ERISA plan regulation as a matter of exclusive federal concern:

> The substantive and enforcement provisions of [ERISA] are intended to preempt the field for Federal regulations, thus eliminating the threat of conflicting or inconsistent State and local regulation of employee benefit plans. This principle is intended to apply in its broadest sense to all actions of State or local governments ... which have the force or effect of law.[8]

However, as this Court has noted, the courts have struggled with the imprecise analysis that relies on the "relate to"

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5 120 Cong. Rec. 29197 (1974) (statement of Representative Dent), cited in *Shaw*, 463 U.S. at 99.

6 *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523 (1981).

7 *Shaw*, 463 U.S. at 96.

8 120 Cong. Rec. 29933 (1974) (statement of Senator Williams), cited in *Shaw*, 463 U.S. at 99.

clause to identify the scope of the preempted field.[9] This case provides the Court with an ideal opportunity to clarify the meaning of "field preemption."

Section 502(a), 29 U.S.C. § 1132(a), provides the exclusive civil enforcement mechanism for claims to recover benefits or enforce ERISA plan rights. Claims for ERISA benefits necessarily arise under this provision – whether brought initially under state or federal law – and are impliedly or completely preempted; any such claim states an ERISA claim and is removable to federal court. *Davila*, 542 U.S. at 209. *See also Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 66 (1987) (Congress clearly manifested intent to make causes of action within the scope of the civil enforcement provisions of §502(a) removable to federal court). Where state law provides an alternative enforcement mechanism outside this federal scheme, it "conflicts with the clear congressional intent to make the ERISA remedy exclusive and is therefore preempted." *Davila*, 542 U.S. at 209.

Notwithstanding Congress's clearly expressed intent, the explicit statutory provisions, and the 21 preemption

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[9] *Dillingham*, 519 U.S. at 336 (Scalia, J., concurring; Ginsburg, J., joining) (noting dissatisfaction with "relate to" analysis as a test for pre-emption, Justice Scalia states, "... [I]t accurately describes our current ERISA jurisprudence to say that we apply ordinary field pre-emption, and, of course, ordinary conflict pre-emption."); *Egelhoff*, 532 U.S. at 153 (Scalia, J., concurring; Ginsburg, J., joining) ("[W]e can bring some coherence to this area...only by interpreting the 'relate to' clause as a reference to our ordinary pre-emption jurisprudence."); *Egelhoff*, 532 U.S. at 153 (Breyer, J., dissenting; Stevens, J., joining) (agreeing with Justice Scalia that court should apply normal conflict and field preemption principles rather than struggle to interpret the "relate to" clause).

decisions issued by this Court since ERISA's enactment,[10] the scope of ERISA preemption has remained a source of confusion. This case presents this Court with the opportunity to provide more definitive guidance to employers, employees, ERISA plans, plan participants, plan fiduciaries, plan sponsors, and reviewing courts.

For example, ERISA explicitly requires all governing plan documents to "specify the basis on which payments are made to and from the plan,"[11] thus placing the manner of benefits payment squarely within the plan sponsor's control. Despite this statutory directive and precisely analogous decisions to the contrary, the Fifth Circuit decision validates a state statute that ignores ERISA requirements and mandates the inclusion of crucial payment terms for all employee welfare benefit plans. Moreover, because the

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[10] *Aetna Health Inc. v. Davila*, 542 U.S. 200 (2004); *Ky. Ass'n of Health Plans, Inc. v. Miller*, 538 U.S. 329 (2003); *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002); *Egelhoff v. Egelhoff*, 532 U.S. 141 (2001); *UNUM Life Ins. Co. of Am. v. Ward*, 526 U.S. 358 (1999); *Boggs v. Boggs*, 520 U.S. 833 (1997); *De Buono v. NYSA-ILA Medical & Clinical Services Fund*, 520 U.S. 806 (1997); *California Div. of Labor Stds. Enforcement v. Dillingham Constr., N.A., Inc.*, 519 U.S. 316 (1997); *New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995); *John Hancock Mut. Life Ins. Co. v. Harris Trust & Sav. Bank*, 510 U.S. 86 (1993); *District of Columbia v. Greater Washington Bd. of Trade*, 506 U.S. 125 (1992); *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990); *FMC Corporation v. Holliday*, 498 U.S. 52 (1990); *Massachusetts v. Morash*, 490 U.S. 107 (1989); *Mackey v. Lanier Collection Agency & Serv.*, 486 U.S. 825 (1988); *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1 (1987); *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987); *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, (1985); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983); *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504 (1981).

[11] ERISA Section 402(b)(4), 29 U.S.C. § 1102(b)(4).

panel determined that the Assignment Statute does not even satisfy the threshold "relate to" test for ERISA preemption, the decision arguably applies to all ERISA welfare plans, including self-funded as well as insured plans.[12]

The panel decision allows the state legislature to flout controlling, lawful ERISA plan terms and interfere with an ERISA plan sponsor's right to structure a benefits program in the manner it wishes, contravening the voluntary nature of ERISA welfare benefit plans. *See, e.g., Curtiss-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 78 (1995) (ERISA does not create any substantive entitlement to employer-provided health benefits; plan sponsors are generally free, for any reason at any time, to adopt, modify or terminate welfare plans). In addition, the panel decision conflicts directly with congressional intent that ERISA "enable employers 'to establish a uniform administrative scheme [and] a set of standard procedures to guide processing of claims and disbursement of benefits.' ... Uniformity is impossible... if plans are subject to different legal obligations in different states." *Egelhoff*, 532 U.S. at 148 (citation omitted). A state law that adds to the judicial remedies provided by ERISA "patently violates ERISA's policy of inducing employers to offer benefits by assuring a predictable set of liabilities, under uniform standards of primary conduct and a uniform regime of ultimate remedial orders and awards..." *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 379 (2002). Moreover, the panel decision ignores congressional intent to minimize cost burdens on plans through ensuring uniformity

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[12] ERISA welfare benefit plans may either self-insure or purchase insurance from an insurance company to satisfy their obligations to participants. Those plans that do not purchase an insurance policy are called "self-funded" or "self-insured" plans; those that purchase insurance are called "insured" or "fully insured" plans. *See Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 732 (1985); *FMC Corp. v. Holliday*, 498 U.S. 52, 54 (1990).

and predictability; *see, e.g., Varity Corp. v. Howe*, 516 U.S. 489, 497 (1996) (courts should consider "competing congressional purposes, such as Congress' desire to offer employees enhanced protection for their benefits, ... and, ... its desire not to create a system that is so complex that administrative costs, or litigation expenses, unduly discourage employers from offering welfare benefit plans in the first place.")

Justices of this Court have bemoaned the fact that "our prior decisions have not succeeded in bringing clarity to the law."[13] Review of the panel's decision here – which muddies the ERISA preemption quagmire – provides an ideal occasion for this Court to provide that clarity, both with respect to express preemption of state laws that relate to the field of employee benefit plans, and implied preemption of state laws that conflict with ERISA's exclusive civil enforcement scheme.

II. ARGUMENT

A. The Court should grant review because the Fifth Circuit decision conflicts with Supreme Court authority requiring preemption of state laws that relate to ERISA plan administration.

Under ERISA, the governing plan documents are paramount. Every plan must be established and maintained pursuant to a written instrument.[14] Plan administration obligations and duties are set forth in and derive from the

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[13] *Dillingham*, 519 U.S. at 335 (Scalia, J., concurring; Ginsburg, J., joining); *Egelhoff*, 532 U.S. at 153 (Scalia, J., concurring; Ginsburg, J., joining, *and* Breyer, J., dissenting; Stevens, J., joining). *See* footnote 9, *supra*.

[14] ERISA Section 402(a)(1), 29 U.S.C. § 1102(a)(1).

ERISA plan terms. ERISA requires that the governing plan documents include provisions that "specify the basis on which payments are made to and from the plan."[15] ERISA further requires a plan fiduciary to administer the plan "in accordance with the documents ... governing the plan," making payments to a "person designated by a participant, or by the terms of [a plan], who is or may become entitled to a benefit thereunder."[16] A plan participant or beneficiary may bring an action "to recover benefits due ... *under the terms of his plan*, to enforce his rights *under the terms of the plan*, or to clarify his rights to future benefits *under the terms of the plan*..."[17]

Consistent with ERISA directives regarding the supremacy of ERISA plan terms, state laws relate to ERISA, and must be preempted, if they purport to regulate the administration and structure of an ERISA plan, as reflected in those plan terms. ERISA's express preemption provision provides that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a)...." ERISA Section 514(a), 29 U.S.C. § 1144(a).

Although this Court's interpretation of this "relate to" clause has evolved in the 30 years since ERISA's enactment, one constant remains: State laws have an impermissible connection with ERISA plans, and are preempted by ERISA, if they regulate matters relating to plan administration, benefit payment, and ERISA obligations, "thus implicat[ing]

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15 ERISA Section 402(b)(4), 29 U.S.C. §§ 1102(b)(4).

16 ERISA Sections 404(a)(1)(D) and 3(8), 29 U.S.C. §§1104(a)(1)(D) and 1002(8), respectively.

17 ERISA Section 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B) (emphasis added).

an area of core ERISA concern." *Egelhoff*, 532 U.S. at 147. *See also Travelers*, 514 U.S. at 658 (state law has impermissible connection with an ERISA plan if it mandates employee benefit structure or its administration); *Dillingham*, 519 U.S. at 333 (state law has impermissible connection with an ERISA plan if it is "tantamount to a compulsion" upon the plan).

The panel decision contravenes or overlooks authority from this Court regarding ERISA's preemptive power over state laws that compel plan structures or require administrators to pay benefits in a particular manner. This Court in *Egelhoff* held that ERISA preempted a state statute that revoked, upon divorce, a former spouse's designation as beneficiary under the terms of the plan. This Court held the state statute had an impermissible connection with, and thus related to, ERISA because it "binds ERISA plan administrators to a particular choice of rules for determining beneficiary status. The administrators must pay benefits to the beneficiaries chosen by state law, *rather than to those identified in the plan documents*." 532 U.S. at 147 (emphasis added). The statute violated ERISA "because under this statute, the only way the fiduciary can administer the plan according to its terms is to change the very terms he is supposed to follow." 532 U.S. at 151 n.4.

The panel's efforts to distinguish *Egelhoff* are unconvincing. For example, in concluding that its decision is consistent with ERISA's definition of "beneficiary," the panel gives short shrift to the express statutory terms. ERISA Section 3(8) defines a beneficiary as "a person designated by a participant, or by the terms of an employee benefit plan, *who is or may become entitled to a benefit thereunder*." 29 U.S.C. § 1002(8) [emphasis added].[18]

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[18] "...[A] 'beneficiary' is not anyone who claims to be one...[but] is one who has a reasonable or colorable claim to benefits.'" *Cobb v.*

Significantly omitted from the panel's analysis is consideration of the ERISA requirement that the designated beneficiary be *entitled to benefits under the terms of the plan.* This Court explicitly based its *Egelhoff* preemption ruling in part on the principle that an ERISA beneficiary, no matter how the designation is accomplished, must be a permissible beneficiary under the plan terms, holding the Washington statute preempted because it mandated benefit payments to beneficiaries chosen by state law *in contravention of valid plan terms:*

> The statute ... runs counter to ERISA's commands that a plan shall 'specify the basis on which payments are made to and from the plan,' § 1102(b)(4), and that the fiduciary shall administer the plan 'in accordance with the documents and instruments governing the plan,' § 1104(a)(1)(D), making payments to a 'beneficiary' who is 'designated by a participant, or by the terms of [the] plan.' § 1002(8).

532 U.S. at 147. Though it quoted selectively from *Egelhoff,* the panel failed to follow its overriding instruction to evaluate the validity of a state statute by considering its impact on the ERISA objectives of ensuring that plan administration, and benefit payment, occur in accordance with valid plan provisions, unencumbered by disparate state laws purporting to regulate matters relating to plan administration and benefit payment.

Cent. States, 461 F.3d 632, 635 n.3 (5th Cir. 2006) (citation omitted). *Egelhoff* confirms that if the plan prohibits payment of benefits to a non-participating provider, such a provider cannot be a valid beneficiary.

B. The Court should grant review because the Fifth Circuit decision conflicts directly with decisions of other circuits.

The panel acknowledged that its decision is in direct conflict with those of the Eighth and Tenth Circuits. "We acknowledge that both the Eighth and Tenth Circuits have concluded that ERISA preempts similar assignment statutes." 461 F.3d at 539 (App. at 18a). The existence of this conflict supports the granting of Blue Cross's petition. *See* S. Ct. R. 10(a); *Braxton v. United States*, 500 U.S. 344, 347 (1991) ("A principal purpose for which we use our certiorari jurisdiction ... is to resolve conflicts among the United States courts of appeals ... concerning the meaning of provisions of federal law.").

In *Arkansas Blue Cross & Blue Shield v. St. Mary's Hosp., Inc.*, 947 F.2d 1341 (8th Cir. 1991), *cert. denied*, 504 U.S. 957 (1992), the Eighth Circuit determined that ERISA preempted an Arkansas statute requiring recognition of all assignments, including assignments of insurance benefits, because the statute negated the ERISA plan's non-assignment provision; shifted control over benefits payments from administrator to beneficiary, thus changing the plan structure and affecting the relationship between primary ERISA entities; had an intrastate and interstate impact on plan administration; and had an economic impact on ERISA plans resulting from elimination of an incentive for provider participation agreements. In *St. Francis Regional Medical Ctr. v. Blue Cross & Blue Shield*, 49 F.3d 1460 (10th Cir. 1995), the Tenth Circuit held that an analogous state statute related to ERISA plans because its enforcement would directly impact ERISA plan provisions. The Tenth Circuit determined that allowing states to dictate the assignability of benefits would constitute an "improper interference" with ERISA plans and Congress's "laissez-faire attitude of

declining to establish any statutory rule" regarding assignability. 49 F.3d at 1464.[19]

As justification for creating this split of authority, the panel opined that the other circuits misinterpreted ERISA's silence regarding assignment of benefits, and that intervening Supreme Court authority rendered the conflicting decisions no longer valid. Blue Cross respectfully submits that both of these justifications are misguided and unsupported by the law.

In the panel's view, congressional silence regarding assignability is irrelevant to its determination of whether ERISA preempts the Assignment Statute; to the extent the Eighth and Tenth Circuits held otherwise, the panel asserts they were incorrect. The panel's conclusion conflicts with decisions in other circuits,[20] as well as decisions within the Fifth Circuit,[21] holding that assignability is a matter left to

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[19] District courts within the Seventh Circuit also have held ERISA preempts state assignment or direct payment statutes; *see DeBartolo v. Blue Cross Blue Shield of Illinois*, No. 01 C 5940, 2001 WL 1403012 (N.D. Ill. Nov. 9, 2001); *Surgicore, Inc. v. Principal Life Ins. Co.*, No. 01 C 9387, 2002 WL 1052034 (N.D. Ill. May 22, 2002).

[20] *See, e.g., City of Hope Nat'l Med. Center v. Healthplus, Inc.*, 156 F.3d 223, 229 (1st Cir. 1998) (ERISA leaves assignability or non-assignability of ERISA plan health benefits to negotiations of contracting parties); *Physicians Multispecialty Group v. Health Care Plan of Horton Homes, Inc.*, 371 F.3d 1291, 1295 (11th Cir.) (ERISA-governed plans are contracts, and parties are free to bargain for certain provisions, including assignability; unambiguous anti-assignment provision in ERISA-governed welfare benefit plan is valid and enforceable), *cert. denied*, 543 U.S. 1002 (2004).

[21] *See, e.g., LeTourneau Lifelike Orthotics & Prosthetics, Inc. v. Wal-Mart Stores, Inc.*, 298 F.3d 348, 353 (5th Cir. 2002) (ERISA plan's anti-assignment provision was valid and rendered nugatory any purported assignment).

the negotiation of the parties to the ERISA contract, an anti-assignment clause in an ERISA plan is lawful and enforceable, and an assignment is ineffectual if the ERISA plan contains an anti-assignment provision. These courts relied on the same principles that informed the determinations in the Eighth and Tenth Circuits that state anti-assignment statutes must be preempted; namely, that Congress's silence regarding assignments in welfare plans shows an intent "to allow the free marketplace to work out such competitive, cost effective, medical expense reducing structures as might evolve." *Davidowitz v. Delta Dental Plan, Inc.*, 946 F.2d 1476, 1481 (9th Cir. 1991).

The panel considered *St. Mary's* and *St. Francis* unpersuasive for the additional reason that they were decided before this Court's decision in *Travelers*. However, this Court in *Travelers* reaffirmed that ERISA preempts state laws that impact ERISA obligations, *i.e.*, because they (1) entitled employees to "benefits in excess of what plan administrators intended to provide," (2) "prevent[ed] plans from using a method of calculating benefits permitted by federal law," (3) "mandated employee benefit structures or their administration," or (4) provided "alternative enforcement mechanisms." 514 U.S. at 658. These factors, expressly still relevant under the less literal analysis endorsed by *Travelers*, are met by the Assignment Statute. The conflicting Eighth and Tenth Circuit decisions relied on these factors, and thus *Travelers* has no impact on their continued validity; *see St. Mary's* (concluding assignment statute "relates to" ERISA plan after considering factors such as negation of plan provision, effect on ERISA entities and plan structure, and impact on plan administration). *See also UNUM Life Ins. Co. of Am. v. Ward*, 526 U.S. 358, 379 (1999) (state agency law that makes employer agent of insurer in performing plan administration duties relates to and is preempted by ERISA because it would have marked

effect on plan administration duties, including bookkeeping obligations regarding to whom benefit checks must be sent, and basic administrative services).

C. The Court should grant review because the Fifth Circuit decision conflicts with Supreme Court authority requiring preemption of state laws that conflict with ERISA's exclusive enforcement mechanism.

As this Court has recognized frequently and consistently, Congress enacted ERISA to protect the interests of participants in benefit plans by establishing a uniform and comprehensive regulatory regime that provides appropriate remedies, sanctions, and access to the Federal courts. *Davila*, 542 U.S. at 208. ERISA's expansive preemption provisions are intended to ensure that this regulation is "exclusively a federal concern," *id.*, citing *Alessi.*[22] The panel decision undermines this comprehensive regulatory framework and the principles of uniformity on which it is based.

In furtherance of this congressional purpose, ERISA's integrated enforcement mechanism is intended to provide the exclusive means of enforcement and remediation. *Id.* "The policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA." *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54 (1987). Against this clear expression of policy, citing *Ingersoll-Rand Co. v. McClendon,* 498 U.S. 133, 143-145 (1990), this Court held in *Davila* that "any state-law cause of action that duplicates, supplements, or supplants the ERISA

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[22] 451 U.S. at 523.

civil enforcement remedy conflicts with the clear congressional intent to make the ERISA remedy exclusive and is therefore pre-empted," even if the state law would otherwise be saved from preemption as a law regulating insurance. *Id.*, at 542 U.S. at 209, 217.[23] *See also Rush Prudential,* 536 U.S. at 377 ("Although we have yet to encounter a forced choice between the congressional policies of exclusively federal remedies and the 'reservation of the business of insurance to the States,' . . . [T]he state insurance regulation [loses] out if it allows plan participants 'to obtain remedies ... that Congress rejected in ERISA,' [citations omitted].").

Under *Davila,* the Assignment Statute should be preempted because it establishes expressly a state cause of action "to collect benefits," thereby supplementing or supplanting ERISA's benefit claim procedure, and provides an extra-contractual remedy – payment of benefits to a provider in accordance with state law and in conflict with ERISA's exclusive civil enforcement scheme.

The panel decision sanctions the following scenario: A plan participant seeks medical services from a hospital outside his ERISA plan's participating provider network. Upon admission to the hospital, the participant is required to sign a form that purports to assign his right to plan benefits

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[23] In *Davila*, this Court also held that the "extraordinary pre-emptive power" of ERISA's civil enforcement provisions not only resulted in preemption of duplicative or supplementary state-law causes of action, but completely preempted such state law claims for ERISA benefits, converting them into federal law claims, removable to federal court. 542 U.S. at 209. Complete preemption, which addresses federal jurisdiction and removal, is not directly at issue in this lawsuit. Blue Cross submits, however, that if a hospital asserted a state law claim for benefits in state court, under *Davila*, it would be completely preempted and removable to federal court.

to the hospital. The hospital provides medical services and submits an invoice to Blue Cross, seeking payment of the plan benefits. However, following lawful ERISA plan provisions that prohibit assignments and permit direct payment of benefits only to plan participants or participating network providers, Blue Cross paid or will pay the plan benefits directly to the participant, rather than to the hospital.

The hospital then sues Blue Cross, seeking payment of those same benefits. Pursuant to ERISA and the lawful plan terms, the hospital is not a valid assignee, and therefore has no standing to assert an ERISA claim. Moreover, pursuant to ERISA and the lawful plan terms, Blue Cross has fulfilled its ERISA obligations in the only permissible way: by paying benefits directly to the participant.

Pursuant to the Louisiana Assignment Statute, however, the hospital may bring a state law cause of action against Blue Cross "to collect benefits," and Blue Cross is precluded from asserting as a defense the prior benefit payment to the participant. If the hospital prevails, state law compels Blue Cross to pay a sum of money to the hospital, representing a duplicate payment on the same obligation, or a penalty, either of which is an extra-contractual or punitive remedy not permitted under the terms of the plan or ERISA.[24]

The panel decision thus allows state law to trump not only lawful ERISA plan terms relating to plan administration and benefit payment obligations, but ERISA § 502(a)(1)(B),

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[24] *See, e.g., Clancy v. Employers Health Ins. Co.*, 101 F. Supp. 2d 463, 467 (E.D. La. 2000) (ERISA preempts timely payment statute, LSA-R.S. 22:657, because by providing a penalty, it creates a "supplemental" state law remedy that conflicts with ERISA §502(a)'s exclusive remedy provision).

29 U.S.C. § 1132(a)(1)(B), the exclusive provision under which an action "to collect" ERISA benefits may be maintained. In addition, the panel decision violates the statutory directive of ERISA that ERISA plans must be administered in accordance with their lawful plan terms. *See Egelhoff*, 532 U.S. at 151 n. 4 ("[U]nder ... ERISA, a fiduciary 'shall' administer the plan 'in accordance with the documents ... governing the plan,' 29 U.S.C. § 1104(a)(1)(D). The [state] statute conflicts with this command because ... the only way the fiduciary can administer the plan according to its terms is to change the very terms he is supposed to follow.")

The panel rejected Blue Cross's argument that the statute contemplates a double payment of the same benefit. The panel reasoned that if Blue Cross complies with the Assignment Statute, it only pays the benefit once, and any "mistaken" payment to the participant could be remedied by seeking recovery of that payment from the person improperly paid. "Failure to follow the law cannot create preemption concerns." 461 F.3d at 536 (App. at 11a). What the panel ignores, however, are Blue Cross's obligation to follow federal law, which mandates benefit payment in accordance with plan terms, as well as the fact that those plan terms are lawful terms under ERISA. A payment to the plan participant will not be "mistaken"; rather, under ERISA, it is the only lawful result: a payment required by the plan and, thus, by the ERISA mandate to follow plan terms. The Assignment Statute purports to write this lawful term out of the plan, converting a term that is lawful under ERISA into one unlawful under state law. If the direct payment provision is in the plan, as ERISA permits, Blue Cross cannot comply with both state law and federal law. Thus, under the traditional "conflict preemption" analysis advocated by Justices of this Court in recent decisions, the

Assignment Statute must be preempted.[25] The panel held further that the Assignment Statute need not be preempted because "it does not impose any additional obligation on the ERISA plan administrator, nor does it create additional or separate means of enforcement," citing *Rush Prudential*, 536 U.S. at 379. The Assignment Statute clearly obliges the ERISA plan to pay benefits unauthorized under the plan terms, and provides the hospital-assignee with a separate means of enforcement under state law. The hospital is not a valid assignee under the plan, and therefore has no ERISA standing to assert a right to benefits; thus, the state law claim is in addition to or separate from an ERISA claim for benefits. An action under ERISA § 502(a) for benefits under one of Blue Cross's plans would have as an available remedy only the payment of benefits in the manner specified under the plan. The Assignment Statute "enlarges the claim" available under § 502(a) because it requires Blue Cross to pay money to the hospital even if it has already paid benefits to the participant, and even though the plan prohibits such payment, thereby creating an extra-contractual remedy that amounts to a penalty for following ERISA plan terms. Such extra-contractual relief is not available under ERISA. *See Mass. Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 146-147 (1985) (Congress did not provide, and did not intend the judiciary to imply, a cause of action for extra-contractual damages caused by improper processing of benefit claims). The Assignment Statute thus is "incompatible with ERISA's enforcement scheme" because it "provide[s] a form of ultimate relief in a judicial forum that add[s] to the judicial

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[25] Where compliance with both state law and ERISA is impossible, Congress intended that the state law must yield. *Boggs v. Boggs*, 520 U.S. 833, 844 (1997) (preemption required 'where compliance with both federal and state regulations is a physical impossibility, ... or where state law stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress.'(citation omitted)).

remedies provided by ERISA," and "enlarge[s] the claim beyond the benefits available in any action brought under 1132(a)," *Rush Prudential,* 536 U.S. at 379-380.

D. This Court's review is warranted to resolve recurring questions of considerable significance to preemption jurisprudence, and of practical importance to the health care community.

Review by this Court is warranted not only to correct the panel's departure from precedents of this Court and of two other circuits, but to provide guidance on matters of public policy and federal preemption.

As a public policy matter, the issue presented here is of great significance to the parties impacted directly – employers who sponsor Blue Cross ERISA plans, plan participants, plan administrators, and health care providers both within and outside of the Blue Cross networks – as well as to the health care community generally. ERISA is structured to permit employers to choose whether to offer plans and to determine the plan's design. *See, e.g., Lockheed Corp. v. Spink*, 517 U.S. 882, 887 (1996) (nothing in ERISA requires employers to establish employee benefits plans, nor does ERISA mandate what kind of benefits employers must provide). In making plan design decisions, employers seek to structure plans that are affordable both to the employer-sponsor and the employee-participant. This Court has recognized the "tension between the primary [ERISA] goal of benefiting employees and the subsidiary goal of containing pension costs." *Mertens v. Hewitt Associates*, 508 U.S. 248, 262 (1993) (citing *Alessi*, 451 U.S. at 515). Participating provider networks serve the public interest by keeping health care costs lower, and ERISA plans pass those savings on to plan participants. A plan provision that permits direct payment of benefits only to participating providers is

intended to induce providers to join the plan's participating provider network, thereby contributing to cost control. The Assignment Statute operates to eliminate this incentive and the resulting cost-savings, regardless of the plan sponsor's intended choice. The panel's decision represents a critical error and is so broadly worded that, arguably, it impacts all ERISA plans, included self-funded as well as insured plans. By sanctioning a state's direct regulation of ERISA plans, the panel decision will increase healthcare costs and discourage employers from establishing plans.

Respondents assert that the Assignment Statute serves the public interest by facilitating the delivery of medical treatment, 461 F.3d at 541 (App. at 20a), but it is not clear that ERISA plan participants, if given the choice, would choose the higher costs that would result from the diminution or elimination of the participating provider scheme. To the extent the Louisiana state legislature has "chosen assignment of benefit claims over inducing hospitals to enter into Blue Cross's provider networks," as the panel suggests, *id.,* Blue Cross respectfully submits that this public policy choice is in error. In addition, a policy choice such as this one, that impacts the establishment of ERISA employee health benefit plans, should be made by Congress. *See Rush Prudential*, 536 U.S. at 402 (Thomas, J., dissenting) (while the advantages of allowing states to implement independent review requirements as a supplement to ERISA's exclusive enforcement scheme may outweigh any resultant disincentive to the formation of ERISA health benefit plans, this is a judgment that must be made by Congress).

Moreover, as a jurisprudential issue, this Court has recognized that the uncertainties of ERISA preemption have created an "avalanche of litigation"[26] both in this Court and

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[26] *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund,* 520 U.S. 806, 808 n.1 (1997).

in the lower courts.[27] The panel decision does little to restrain the avalanche; it creates a circuit split that flouts ERISA's framework and Congress's intent to ensure uniformity of enforcement. The Assignment Statute creates a new cause of action for ERISA benefits that "patently violates ERISA's policy of inducing employers to offer benefits by assuring a predictable set of liabilities, under uniform standards of primary conduct and a uniform regime of ultimate remedial orders and awards when a violation has occurred." *Rush Prudential*, 536 U.S. at 379. This case presents an ideal vehicle for this Court not only to resolve the particular conflict among the circuits, but to revisit the purpose of ERISA preemption and craft an analytical scheme that would lend much-needed clarity to the law.

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[27] The importance of ERISA preemption issues is underscored further by a simple Westlaw search for the time period of December 2005 through November 2006. A Westlaw search of United States District Court and United States Court of Appeals opinions deciding ERISA preemption issues demonstrates that approximately 500 opinions were issued on this topic in the preceding year.

CONCLUSION

For the foregoing reasons, the petition for a writ of certiorari should be granted.

Respectfully submitted,

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APPENDIX A
DECISION OF THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT
AUGUST 16, 2006

United States Court of Appeals,
Fifth Circuit.

LOUISIANA HEALTH SERVICE & INDEMNITY CO., d/b/a Blue Cross and Blue Shield of Louisiana, Plaintiff-Intervenor Defendant-Appellant,

v.

RAPIDES HEALTHCARE SYSTEM; State of Louisiana; Charles R. Foti, Jr., Attorney General for the State of Louisiana, Defendants-Appellees,

v.

Dauterive Hospital, Intervenor Defendant-Appellee.

No. 04-31114.

461 F.3d 529

Aug. 16, 2006.

Appeal from the United States District Court for the Middle District of Louisiana.

Before HIGGINBOTHAM, DeMOSS and OWEN, Circuit Judges.

PATRICK E. HIGGINBOTHAM, Circuit Judge:

Section 40:2010 of the Louisiana Revised Statutes requires insurance companies to honor all assignments of benefit claims made by patients to hospitals. This case asks us to decide whether the Employee Retirement Income Security Act of 1974 preempts the assignment statute to the extent

that it applies to fully insured ERISA plans. We hold that Louisiana's assignment statute is not preempted.

I

The relevant facts in this case are undisputed. Section 40:210 [sic] of the Louisiana Revised Statutes (the "assignment statute") provides, in relevant part:
Itemized statement of billed services by hospitals.

... No insurance company, employee benefit trust, self-insurance plan, or other entity which is obligated to reimburse the individual or to pay for him or on his behalf the charges for the services rendered***531** by the hospital shall pay those benefits to the individual when the itemized statement submitted to such entity clearly indicates that the individual's rights to those benefits have been assigned to the hospital. When any insurance company, employee benefit trust, self-insurance plan, or other entity has notice of such assignment prior to such payment, any payment to the insured shall not release that entity from liability to the hospital to which the benefits have been assigned, nor shall such payment be a defense to any action by the hospital against the entity to collect the assigned benefits.[1]

The assignment statute is included in the "State Department of Hospitals" chapter of Louisiana's Public Health and Safety code. As the title indicates, the statute imposes various additional requirements on hospitals regarding itemized statements of billed services to patients. Those requirements are not at issue in this case.

Two hospitals, defendant Rapides Health Care System and intervenor Dauterive Hospital (collectively, "the Hospitals"),

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[1] La.Rev.Stat. Ann. § 40:2010 (2004).

complained to the Louisiana Department of Insurance ("DOI") that Louisiana Health Service & Indemnity Co., d/b/a Blue Cross and Blue Shield of Louisiana, failed to comply with the assignment statute after the Hospitals terminated their participating provider agreements with Blue Cross. While the DOI investigated the complaints, ultimately concluding that Blue Cross's policy provisions violated the assignment statute, Blue Cross filed the present case against Rapides, the State of Louisiana, and the Louisiana attorney general, seeking a declaration that the assignment statute is preempted by ERISA to the extent that it applies to ERISA employee welfare benefit plans insured or administered by Blue Cross. Dauterive intervened.

All health insurance plans issued and administered by Blue Cross contain provisions governing the assignment of benefits. The parties agree that all provisions are substantially similar to the following:

Direct Payment to Member

1. All benefits payable by the Company [Blue Cross] under this Benefit Plan and any amendment hereto are personal to the Member and are not assignable in whole or in part by the Member. The Company has the right to make payment to a Hospital, Physician, or other Provider (instead of to the member) for Covered Services which they provided while there is in effect between the Company and any such Hospital, Physician, or other Provider an agreement calling for the Company to make payment directly to them. In the absence of an agreement for direct payment, the Company will pay to the Member and only the Member those Benefits called for herein and the Company will not recognize a member's attempted assignment to, or direction to pay, another, except as required by law.

* * *

3. If the Company has offered a Hospital, Physician, or other Provider an agreement for direct payment by the Company, but there is no such agreement in effect when Covered Services are rendered to a Member by such Hospital, Physician, or other Provider, the Company will not recognize a Member's attempted assignment to, or direction to pay, such Hospital, Physician, or other Provider. The Company will pay to the Member and only the Member ***532** those Benefits called for in this Benefit Plan and any amendment thereto.

Blue Cross divides hospitals into "participating providers" and "nonparticipating providers." Blue Cross's agreement with participating providers includes a provision allowing or requiring direct payment to the provider. With nonparticipating providers, there is no agreement, and, pursuant to the above language, Blue Cross will not honor a patient's assignment of benefits to the provider. The burden is then on the nonparticipating provider to collect its fees directly from the patient. Blue Cross does not dispute that its refusal to honor assignments to nonparticipating providers violates the assignment statute.

Blue Cross moved for summary judgment on the ERISA preemption issue in August 2001. Finding only an indirect economic effect on ERISA plans, the district court denied summary judgment, reasoning that the assignment statute "facilitate[d] and promote[d] the goals of ERISA" and that it was a health-care regulation within an area of state law that Congress did not intend to preempt. As such, the district court did not need to consider whether the statute was saved from preemption as a law regulating insurance. In the alternative, the court concluded that the language of Blue

Cross's health care plan requires compliance, because the anti-assignment provision says that such assignments will not be honored "except as required by law."[2]

Over the next two years, Blue Cross and the Hospitals litigated various other claims that were later settled and are not at issue on appeal. In June 2004, both parties filed motions for summary judgment on the preemption issue. Blue Cross argued that the Supreme Court's intervening decision in *Aetna Health Inc. v. Davila* [3] and the Third Circuit's decision in *Barber v. UNUM Life Insurance Co.* [4] required preemption of the assignment statute because it conflicted with the exclusive enforcement provision in ERISA. Adopting its previous ruling and reasoning, the district court denied Blue Cross's motion and granted the motions filed by the State of Louisiana and the Hospitals. The court concluded that because ERISA is silent regarding assignment of health benefits, the assignment statute does not alter an existing ERISA provision and, thus, was not conflict preempted. The court distinguished *Davila* and *Barber* as cases involving state statutes that altered existing ERISA provisions. Blue Cross timely appealed. We have jurisdiction under 28 U.S.C. § 1291.

II

First, we address whether the plain language of Blue Cross's ERISA plans requires compliance with the assignment statute. If so, then we would not need to reach the preemption questions. [5] If the ERISA plans at issue do not

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[2] *La. Health Serv. & Indem. Co. v. Rapides Healthcare Sys.*, 213 F.Supp.2d 650 (M.D.La.2002) (Brady, J.).

[3] 542 U.S. 200, 124 S.Ct. 2488, 159 L.Ed.2d 312 (2004).

[4] 383 F.3d 134 (3d Cir.2004).

[5] *See Arana v. Ochsner Health Plan*, 352 F.3d 973, 976 (5th Cir.2003) (declining to reach preemption question where no conflict existed); *see*

require compliance with the assignment statute, then we must address Blue Cross's two-prong preemption attack. Blue Cross contends, first, that the assignment statute is ***533** preempted because it conflicts with ERISA's exclusive enforcement scheme. [6] Second, Blue Cross contends that the assignment statute is preempted as a statute that "relate[s] to" ERISA. [7] Finally, should we conclude that the assignment statute is preempted as a statute that relates to ERISA, we must determine whether it is "saved" from preemption as a law regulating insurance.[8] Our review is *de novo*. [9]

A

Attempting to displace the preemption issue, the Hospitals contend that there is no conflict between Blue Cross's ERISA plans and the assignment statute because the plan prohibits assignments "except as required by law." The Hospitals contend that this language modifies the express plan terms to require compliance with Louisiana's assignment statute. Blue Cross argues that this provision is trumped by a subsequent provision of the policy, which states that the plan is governed by Louisiana law "except when preempted by federal law." The district court agreed with the Hospitals, concluding that Blue Cross's policy provisions are "automatically amended ... to conform to the requirements"

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also Ashwander v. Tenn. Valley Authority, 297 U.S. 288, 347, 56 S.Ct. 466, 80 L.Ed. 688 (1936) (Brandeis, J., concurring) ("The Court will not pass upon a constitutional question although properly presented by the record, if there is also present some other ground upon which the case may be disposed of.").

[6] Employee Retirement Income Security Act of 1974 § 502(a), 29 U.S.C. § 1132(a) (2004).

[7] *Id.* § 514(a), 29 U.S.C. § 1144(a).

[8] *Id.* § 514(b)(1)(A), 29 U.S.C. § 1144(b)(1)(A).

[9] *Provident Life & Accident Ins. Co. v. Sharpless*, 364 F.3d 634, 640 (5th Cir.2004); *Frank v. Delta Airlines, Inc.*, 314 F.3d 195, 197 (5th Cir.2002).

of the assignment statute. [10]

[1] We disagree. Neither policy provision displaces the preemption analysis in this case. ERISA plans must always conform to state law, but only state law that is valid and not preempted by ERISA. The presence of the phrase "except as preempted by law" serves no additional purpose, as all state laws are potentially subject to ERISA's preemptive force. The two provisions do not forestall determination of the preemption question. To that, we now turn.

[2] Article VI's Supremacy Clause may entail preemption of state law in any of three ways: by express provision, by implication, or by a conflict between state and federal law. [11] Blue Cross advances two separate preemption arguments: first, Blue Cross contends that Louisiana's assignment statute conflicts with ERISA's exclusive enforcement scheme; second, Blue Cross contends that the assignment statute is expressly preempted as it is a law that "relate[s] to" employee benefit plans. Neither argument persuades.

I

[3][4] Under general principles of conflict preemption, a law is preempted "to the extent that it actually conflicts with federal law," [12] that is, when it is impossible to comply with both state and federal law. [13] Further, a state law is conflict ***534** preempted when it "stands as an obstacle to the

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[10] *La. Health Svc. & Indem. Co.*, 213 F.Supp.2d at 657.

[11] *See Pac. Gas & Elec. Co. v. State Energy Res. Conservation & Dev. Comm'n*, 461 U.S. 190, 203-04, 103 S.Ct. 1713, 75 L.Ed.2d 752 (1983); *Rice*, 331 U.S. at 230, 67 S.Ct. 1146.

[12] *English v. Gen. Elec. Co.*, 496 U.S. 72, 79, 110 S.Ct. 2270, 110 L.Ed.2d 65 (1990).

[13] *Silkwood v. Kerr-McGee Corp.*, 464 U.S. 238, 248, 104 S.Ct. 615, 78 L.Ed.2d 443 (1984); *Florida Lime & Avocado Growers, Inc. v. Paul*, 373 U.S. 132, 142-43, 83 S.Ct. 1210, 10 L.Ed.2d 248 (1963).

accomplishment and execution of the full purposes and objectives of Congress."[14]

In *Aetna Health Inc. v. Davila,* the Supreme Court reaffirmed that "any state-law cause of action that duplicates, supplements, or supplants the ERISA civil enforcement remedy conflicts with the clear congressional intent to make the ERISA remedy exclusive and is therefore pre-empted."[15] *Davila* involved a Texas statute that created a cause of action for any person injured by a plan administrator's failure to exercise ordinary care in the handling of coverage decisions. Recognizing ERISA's " 'comprehensive legislative scheme' " and " 'integrated system of procedures for enforcement,' "[16] the Court stated that ERISA's enforcement provision, § 502(a), was "essential to accomplish[ing] Congress' purpose of creating a comprehensive statute for the regulation of employee benefit plans."[17] As ERISA § 502(a)(1)(B) already provided a cause of action for a plan participant to recover wrongfully denied benefits,[18] the alleged injuries covered by the Texas statute were duplicative and, thus, preempted.[19]

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[14] *Hines v. Davidowitz,* 312 U.S. 52, 67, 61 S.Ct. 399, 85 L.Ed. 581 (1941); *Pac. Gas & Elec. Co.,* 461 U.S. at 203-04, 103 S.Ct. 1713.

[15] 542 U.S. 200, 209, 124 S.Ct. 2488, 159 L.Ed.2d 312; *see also Pilot Life Ins. Co. v. Dedeaux,* 481 U.S. 41, 54-56, 107 S.Ct. 1549, 95 L.Ed.2d 39 (1987); *Ingersoll-Rand Co. v. McClendon,* 498 U.S. 133, 143-45, 111 S.Ct. 478, 112 L.Ed.2d 474 (1990).

[16] *Davila,* 542 U.S. at 208, 124 S.Ct. 2488 (quoting *Massachusetts Mut. Life Ins. Co. v. Russell,* 473 U.S. 134, 147, 105 S.Ct. 3085, 87 L.Ed.2d 96 (1985) (internal quotation marks and citation omitted)).

[17] *Davila,* 542 U.S. at 208, 124 S.Ct. 2488; 29 U.S.C. § 1132(a).

[18] ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B) ("A civil action may be brought-(1) by a participant or beneficiary ... (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan.").

[19] *Davila,* 542 U.S. at 214, 124 S.Ct. 2488. At the district court, Blue Cross also relied on the Third Circuit's decision in *Barber v. Unum Life Insurance Co. of Am.*, which considered a Pennsylvania statute providing

Blue Cross contends that *Davila* is controlling because the assignment statute provides a "separate vehicle" for asserting benefits claims, creating a remedy that "duplicates, supplements, or supplants" ERISA's exclusive enforcement scheme. According to Blue Cross, the assignment statute gives hospitals, to which benefits have been assigned in contravention of the plan's express terms, a state-law cause of action against the ERISA plan to collect the assigned benefits. Further, Blue Cross contends the statute creates a supplemental remedy, as it provides that any payment to the participant, in accordance with plan terms, does not release the plan from liability to the hospital. To Blue Cross, the statute authorizes double recovery against the ERISA plan.

[5] Louisiana's assignment statute is readily distinguishable from the Texas law providing a negligence cause of action for the denial of benefits. First, unlike the ***535** enforcement provisions at issue in *Davila,* ERISA is silent on the assignability of employee welfare benefits; it neither prohibits assignments nor mandates recognition of assignments. [20] The Texas statute at issue in *Davila* was

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punitive damages for the bad faith denial of insurance claims. 383 F.3d 134, 136 (3d Cir.2004). That court, relying on *Davila,* concluded that the statute created a conflict with ERISA's exclusive enforcement scheme. *Id.* at 141. For the same reasons *Davila* is not controlling, *Barber* is not persuasive. *See also Cicio v. John Does 1-8,* 385 F.3d 156 (2d Cir.2004) (finding a state law malpractice claim preempted by ERISA because it would provide consequential and punitive damages in connection with a benefits claim); *Land v. CIGNA Healthcare of Fla.,* 381 F.3d 1274 (11th Cir.2004) (state law medical malpractice claim preempted).

[20] *Hermann Hosp. v. MEBA Med. & Benefits Plan,* 845 F.2d 1286, 1289 (5th Cir.1988) ("*Hermann I*") ("ERISA contains no anti-assignment provision with regard to health care benefits of ERISA-governed medical plans, nor is there any language in the statute which even remotely suggests that such assignments are proscribed or ought in any way to be limited."); *cf.* ERISA § 206(d)(1), 29 U.S.C. § 1056(d)(1) (providing,

preempted, in large part, because of the specific enforcement provisions provided by Congress.[21] Second, the assignment statute does not create an additional means to enforce payment of benefits under an ERISA plan. The Texas statute at issue in *Davila,* in contrast, imposed a "duty" on any health maintenance organization "to exercise ordinary care when making health care treatment decisions" and imposed liability for any damages proximately caused by a failure to exercise ordinary care.[22] The assignment of benefits from the patient to the hospital results solely in the transfer of the cause of action provided by § 502(a) from the patient to the hospital. The assignee takes what the assignor had; no more, no less.[23] The assignment statute merely

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with certain exceptions, that "[e]ach pension plan shall provide that benefits provided under the plan may not be assigned or alienated").

[21] *Davila*, 542 U.S. at 208-09, 124 S.Ct. 2488. As the Court noted in *Pilot Life,*

> [T]he detailed provisions of § 502(a) set forth a comprehensive civil enforcement scheme that represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans. The policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA.

Pilot Life Ins., 481 U.S. at 54, 107 S.Ct. 1549; *see also Russell,* 473 U.S. at 146, 105 S.Ct. 3085 ("The six carefully integrated civil enforcement provisions found in § 502(a) ... provide strong evidence that Congress did *not* intend to authorize other remedies that it simply forgot to incorporate expressly.").

[22] *See* Tex. Civ. Prac. & Rem.Code Ann. § 88.002(a) (Vernon 2004) ("A health insurance carrier, health maintenance organization, or other managed care entity for a health care plan has the duty to exercise ordinary care when making health care treatment decisions and is liable for damages for harm to an insured or enrollee proximately caused by its failure to exercise ordinary care."). After *Davila,* the Texas legislature clarified that § 88.002(a) did not apply to employee benefit plans regulated by ERISA. *See id.* § 88.015.

[23] *Tango Transport v. Healthcare Fin. Servs.*, 322 F.3d 888, 894 (5th

passes the sole enforcement mechanism-ERISA § 502-from patient to hospital; it does not impose any additional obligation on the ERISA plan administrator, nor does it create additional or separate means of enforcement. [24]

In addition, Blue Cross argues that the assignment statute authorizes a "double recovery" of employee welfare benefits. According to Blue Cross, it must pay benefits to a patient, in conformance with the express terms of the plan, but that such payment will not discharge liability to a provider that has been assigned the patient's benefits claim. This argument is similarly without merit. Blue Cross's obligation to pay the provider only arises if ***536** Blue Cross has notice of the assignment.[25] If Blue Cross complies with the assignment, then it only pays one time; if Blue Cross ignores the assignment, then it risks paying a claim twice. Failure to follow the law cannot create preemption concerns. Should Blue Cross pay a patient after receiving notice that the patient assigned her benefits claim to a hospital, Blue Cross can seek recovery from the person improperly paid (here, the patient),[26] and Blue Cross recognizes the availability of this remedy in its plan terms, as it reserves the right to recover improper payments.

We conclude that Louisiana's assignment statute is not in conflict with the exclusive enforcement mechanism provided by ERISA. We now turn to Blue Cross's contention that the statute is preempted as a law that "relate[s] to" employee

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Cir.2003); *Hermann Hosp. v. MEBA Med. and Benefits Plan*, 959 F.2d 569, 572 (5th Cir.1992) ("*Hermann II*").

[24] *See Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 379, 122 S.Ct. 2151, 153 L.Ed.2d 375 (2002) (recognizing that "a state regulatory scheme that provides no new cause of action under state law and authorizes no new form of ultimate relief" is not preempted).

[25] *See* La.Rev.Stat. Ann. § 40:2010.

[26] *See Bombardier Aerospace Emp. Wel. Benef. Plan v. Ferrer, Poirot and Wansbrough*, 354 F.3d 348, 356-58 (5th Cir.2003).

benefit plans.

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[6] Congress expressly provides that ERISA "shall supersede any and all State laws insofar as they now or hereafter relate to" any employee benefit plan.[27] Our task is to determine whether the assignment statute "relate[s] to" employee benefit plans. The "unhelpful text" of ERISA's preemption provision neither directs, nor informs, our inquiry;[28] rather, we gain insight solely from the Supreme Court's application of the provision to particular state statutes.

The Supreme Court directs that a law "relates to" an employee benefit plan if "it has a connection with or reference to such a plan."[29] A state law "refers" to an ERISA plan if it acts "immediately and exclusively upon ERISA plans"[30] or if "the existence of an ERISA plan is essential to the law's operation."[31] A law does not refer to an

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[27] ERISA § 514(a), 29 U.S.C. § 1144(a).

[28] *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 654, 115 S.Ct. 1671, 131 L.Ed.2d 695 (1995).

[29] *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96-97, 103 S.Ct. 2890, 77 L.Ed.2d 490 (1983).

[30] *Cal. Div. of Labor Enforcement v. Dillingham Constr.*, 519 U.S. 316, 324-25, 117 S.Ct. 832, 136 L.Ed.2d 791 (1997) (referencing *Mackey v. Lanier Collection Agency & Svc., Inc.*, 486 U.S. 825, 828-30, 108 S.Ct. 2182, 100 L.Ed.2d 836 (1988), in which the Court held that ERISA preempted a state statute that expressly prohibited garnishment of employee welfare plan benefits).

[31] *Dillingham*, 519 U.S. at 324-25, 117 S.Ct. 832 (referencing *District of Columbia v. Greater Wash. Bd. of Trade*, 506 U.S. 125, 130, 113 S.Ct. 580, 121 L.Ed.2d 513 (1992), in which the Court held that ERISA preempted a state statute that applied only to employers who provided health insurance coverage, and *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 139, 111 S.Ct. 478, 112 L.Ed.2d 474 (1990), in which the Court held that ERISA preempted a common-law cause of action premised on the existence of an ERISA plan).

ERISA plan if it applies neutrally to ERISA plans and other types of plans.[32] The "reference to" prong is inapplicable here, as the assignment statute operates without regard to the existence of ERISA plans and does not immediately and exclusively act on such plans: it applies to insurance companies, employee benefit trusts, self-insurance plans, and ***537** other entities that are obligated to reimburse individuals for the charges incurred for hospital services.[33] Thus, the assignment statute is preempted only if it has a "connection with" ERISA plans.

We discern no precise formula for calculating whether a state law has an impermissible connection with an employee benefit plan. The Supreme Court broadly instructs us to look at the objectives of ERISA and the nature and effect of the state law on ERISA plans.[34] In cases like this one, in which Blue Cross contends that federal law bars state action in a field of traditional state regulation,[35] we start with the assumption that "the historic police powers of the States were not to be superseded by [ERISA] unless that was the clear and manifest purpose of Congress."[36] Preemption will

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[32] *Dillingham,* 519 U.S. at 325-28, 117 S.Ct. 832 (refusing to hold that a state statute pertaining to approved apprenticeship programs "referred to" ERISA plans because not all such programs were ERISA plans); *see also Corporation Health Ins. v. Tx. Dep't of Ins.,* 215 F.3d 526, 535 (5th Cir.2000), *op. modified,* 314 F.3d 784 (5th Cir.2002).

[33] *See* La.Rev.Stat. Ann. § 40:2010; *cf. Mackey,* 486 U.S. at 829, 108 S.Ct. 2182 (holding that a Georgia garnishment statute that solely applied to ERISA employee benefit plans was preempted).

[34] *Dillingham,* 519 U.S. at 325, 117 S.Ct. 832 (quoting *Travelers,* 514 U.S. at 656, 115 S.Ct. 1671).

[35] *See, e.g., DeBuono v. NYSA-ILA Med. & Clinical Svcs.,* 520 U.S. 806, 814, 117 S.Ct. 1747, 138 L.Ed.2d 21 (1997) (noting that "the historic police powers of the State include the regulation of matters of health and safety" (citing *Hillsborough County v. Automated Med. Laboratories, Inc.,* 471 U.S. 707, 715, 105 S.Ct. 2371, 85 L.Ed.2d 714 (1985))).

[36] *Travelers,* 514 U.S. at 655, 115 S.Ct. 1671; *Dillingham,* 519 U.S. at 325, 117 S.Ct. 832; *Rice,* 331 U.S. at 230, 67 S.Ct. 1146.

not occur if a state law has only a "tenuous, remote, or peripheral" connection with covered employee benefit plans.[37]

Both parties agree that ERISA is silent on the assignability of employee welfare benefits. As is often the case, congressional silence whispers sweet nothings in the ears of both parties. Blue Cross contends that silence implies that Congress intended to leave the assignment of employee welfare benefits to the free negotiations of the contracting parties; the Hospitals, in contrast, contend that silence speaks and it says that Congress did not intend to preclude statutes mandating enforcement of assignments, especially when considered in light of the express prohibition on the assignment of pension benefits.[38] Congressional silence cannot dictate our conclusion in this case, but we consider what Congress did in order to determine what Congress intended to preclude the states from doing.

Likewise, both parties direct our attention to our prior precedent concerning assignment of benefits. We have held that an assignee has derivative standing to enforce claims under ERISA § 502, thus permitting assignments when not precluded by the plan terms.[39] We have also held that, absent a statute to the contrary, an anti-assignment provision

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[37] *Greater Wash. Bd. of Trade*, 506 U.S. at 130, 113 S.Ct. 580.

[38] *See* ERISA § 206(d)(1), 29 U.S.C. § 1056(d)(1); *cf. Mackey v. Lanier Collection Agency & Serv.*, 486 U.S. 825, 829, 108 S.Ct. 2182, 100 L.Ed.2d 836 (1988) (concluding that a general state garnishment statute's application to employee welfare benefits was not preempted by ERISA because ERISA was silent about enforcement mechanisms for money judgments whereas ERISA explicitly prohibited assignment of pension benefits).

[39] *See Hermann Hosp. v. MEBA Med. & Benefits Plan*, 845 F.2d 1286, 1289 & n. 13 (5th Cir.1988).

in a plan is permissible under ERISA.[40] None of this ***538** resolves the question in this case-namely, whether Louisiana's assignment statute is preempted under ERISA § 514 as a state law that "relate[s] to" employee welfare benefits.

Blue Cross relies primarily on the Supreme Court's decision in *Egelhoff v. Egelhoff*,[41] which concerned a Washington statute that revoked by operation of law the designation of a spouse as the beneficiary of all nonprobate assets, including ERISA plan benefits, upon dissolution of marriage.[42] The Court found fault with two aspects of the Washington statute. First, the statute bound ERISA plan administrators "to a particular choice of rules for determining beneficiary status."[43] To the Court, the statute forced administrators to pay benefits to beneficiaries chosen by state law, rather than those specified in the plan documents. This conflicted with ERISA's requirements that fiduciaries administer plans "in accordance with the documents and instruments governing the plan"[44] and that fiduciaries make payments to beneficiaries "designated by a participant or by the terms of [the] plan."[45]

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[40] *See LeTourneau Lifelike Orthotics & Prosthetics, Inc.*, 298 F.3d 348, 352 (5th Cir.2002) (holding that anti-assignment provisions are not *per se* invalid as applied to health care providers); *see also Physicians Multispecialty Group v. The Health Care Plan of Horton Homes, Inc.*, 371 F.3d 1291, 1295-96 (11th Cir.2004); *City of Hope Nat'l Med. Ctr. v. HealthPlus, Inc.*, 156 F.3d 223, 229 (1st Cir.1998); *Davidowitz v. Delta Dental Plan of Cal., Inc.*, 946 F.2d 1476, 1480-81 (9th Cir.1991).

[41] 532 U.S. 141, 121 S.Ct. 1322, 149 L.Ed.2d 264 (2001).

[42] *See* Wash. Rev.Code § 11.07.010(2)(a) (1994) ("If a marriage is dissolved or invalidated, a provision made prior to that event that relates to the payment or transfer at death of the decedent's interest in a nonprobate asset in favor of or granting an interest or power to the decedent's former spouse is revoked.").

[43] *Egelhoff*, 532 U.S. at 147, 121 S.Ct. 1322.

[44] *Id.* (citing ERISA § 402(b)(4), 29 U.S.C. § 1102(b)(4)).

[45] *Id.* (citing ERISA § 3(8), 29 U.S.C. § 1002(8)).

Second, the Court found the Washington statute interfered with one of the "primary" goals of ERISA: establishing a uniform administrative scheme with a set of standard procedures to guide processing of claims and disbursement of benefits.[46] The existence of the Washington statute required plan administrators to look beyond the plan documents to the effects of state law before making payments to beneficiaries. Exacerbated by various choice-of-law problems, the statute's burden on plan administrators was not militated by provisions protecting administrators from liability unless they had actual knowledge of the dissolution of marriage and permitting administrators to refuse payment until resolving who was a proper beneficiary.[47]

Blue Cross finds both faults in the assignment statute. First, Blue Cross contends *Egelhoff* is controlling because Louisiana's assignment statute binds ERISA plans to a set of rules that govern to whom benefits must be paid in contravention of the plan documents. We disagree. The Washington statute operated as a matter of law, invalidating a plan's designation of beneficiary upon dissolution of marriage. Louisiana's assignment statute, in contrast, requires an affirmative act by the plan participant; it enforces the free will of the plan participant, which is consistent with ERISA's choice of beneficiary. As recognized by the Court in *Egelhoff,* ERISA directs that administrators must pay beneficiaries who are "designated by a participant or by the terms of [the] plan."[48] The Washington statute imposed a third ***539** alternative,

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[46] *Id.; Fort Halifax Packing Co. v. Coyne,* 482 U.S. 1, 9, 107 S.Ct. 2211, 96 L.Ed.2d 1 (1987).

[47] *Egelhoff,* 532 U.S. at 148-50, 121 S.Ct. 1322.

[48] *Id.* at 147, 121 S.Ct. 1322 (citing ERISA § 3(8), 29 U.S.C. § 1002(8)).

requiring payment to beneficiaries designated "by operation of law." Louisiana's assignment statute, in contrast, is consistent with the express terms of ERISA-leaving the beneficiary determination to *either* the person designated by the participant or the person designated by the plan.

We also disagree with Blue Cross's contention that application of the assignment statute will impermissibly interfere with nationally uniform plan administration. To be sure, ERISA was enacted, in large measure, "to establish a uniform administrative scheme" with "a set of standard procedures to guide processing claims and disbursement of benefits."[49] However, a statute's impact on nationally uniform plan administration must be evaluated in light of the particular burden the statute imposes on plan administration. The greater the impact, the greater the burden. As the Court recognized in *Egelhoff,* "all state laws create some potential for lack of uniformity." [50]

Here, the burden on plan administrators is minimal, especially given that Louisiana requires all insurance claims to be submitted on a uniform claim form that includes space for indicating whether benefits have been assigned. [51]

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[49] *Fort Halifax Packing Co.,* 482 U.S. at 9, 107 S.Ct. 2211; *see also Davila,* 542 U.S. at 208, 124 S.Ct. 2488 ("The purpose of ERISA is to provide a uniform regulatory regime over employee benefit plans."); *Ingersoll-Rand,* 498 U.S. at 142-45, 111 S.Ct. 478; *Metropolitan Life Ins. Co. v. Taylor,* 481 U.S. 58, 64-66, 107 S.Ct. 1542, 95 L.Ed.2d 55 (1987).

[50] *Egelhoff,* 532 U.S. at 150, 121 S.Ct. 1322; *see also Rush Prudential HMO, Inc. v. Moran,* 536 U.S. 355, 365, 122 S.Ct. 2151, 153 L.Ed.2d 375 (recognizing that "it was beyond dispute" that a state statute that required all insured benefit plans "to submit to an extra layer of review for certain benefit denials" had a substantial effect on ERISA plans).

[51] *See* La.Rev.Stat. Ann. § 22:213(A)(14) ("Notwithstanding any other law to the contrary, including Paragraph (4) of this Subsection, all claims shall be processed in conformity with the uniform claim form issued by the [DOI].").

Further, the assignment statute will not create any additional paperwork for Blue Cross and, in fact, it may lesson Blue Cross's administrative responsibilities. With or without assignment, Blue Cross will pay benefits only one time, and payment is triggered upon submission of a claim form. To Blue Cross, it should not matter whether that claim form comes from the plan participant, as provided in the plan documents, or from the hospital, as assignee of the participant's benefits claim. Further, as pointed out by amicus curiae, most hospitals file claims with insurance companies electronically, which mitigates the administrative burden. The burden seems greater when many individuals [sic] plan participants must each individually file claims with Blue Cross, especially given the intricacies of coverages, deductibles, and retentions of most health care plans. By consolidating many different individual claims, hospitals can channel expertise in the benefits process. Tellingly, Blue Cross concedes that it must honor assignments made under non-ERISA plans, which suggests that it already has in place some administrative mechanism for complying with the statute. Taken together, the burden imposed by the assignment statute, especially given its consistency with ERISA § 3(8), is minimal, militating concerns over the statute's effect on nationally uniform plan administration.

We acknowledge that both the Eighth and Tenth Circuits have concluded that ERISA preempts similar assignment statutes.[52] After review of those decisions, as ***540** well as intervening Supreme Court precedent, we are convinced that Louisiana's assignment statute does not have the impermissible connection with ERISA plans.

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[52] See *Ar. Blue Cross & Blue Shield v. St. Mary's Hosp., Inc.*, 947 F.2d 1341 (8th Cir.1991); *St. Francis Reg'l Med. Ctr. v. Blue Cross & Blue Shield of Ks., Inc.*, 49 F.3d 1460 (10th Cir.1995).

Both the Eighth and Tenth Circuits interpreted ERISA's silence on the assignability of benefits claims as leaving the issue to the free negotiation and agreement of the parties.[53] As we have already noted, congressional silence points in both directions: either leaving assignment of employee welfare benefits to the parties or leaving room for state regulation, should a state desire to intervene. In *Mackey v. Lanier Collection Agency & Service,* the Supreme Court interpreted congressional silence as to the garnishment of employee welfare benefits not to preempt application of a general garnishment statute to employee welfare benefits, especially in light of an express prohibition on the garnishment of employee pension benefits. [54] Likewise, ERISA specifically precludes assignment of pension plan benefits.[55] As such, "there is no ignoring the fact that, when Congress was adopting ERISA, it had before it a provision to bar the [assignment of ERISA plan benefits], and chose to impose that limitation only with respect to ERISA pension benefit plans, and *not* ERISA welfare benefit plans."[56]

Moreover, both the Eighth and Tenth Circuits decided the preemption question prior to the Supreme Court's rejection, starting in *Travelers,* of an "uncritical literalism" in the application of ERISA's "unhelpful text." [57] As we have

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[53] *St. Mary's Hosp.,* 947 F.2d at 1349 ("[I]f Congress intended that ERISA participants could negotiate plan provisions governing the right to assign welfare benefits, it is more likely that Congress would say nothing at all about welfare benefit assignment."); *St. Francis,* 49 F.3d at 1464 ("We interpret ERISA as leaving the assignability of benefits to the free negotiations and agreement of the contracting parties.").

[54] 486 U.S. 825, 836, 108 S.Ct. 2182, 100 L.Ed.2d 836.

[55] ERISA § 206(d)(1), 29 U.S.C. § 1056(d)(1).

[56] *Mackey,* 486 U.S. at 837, 108 S.Ct. 2182.

[57] 514 U.S. 645, 656, 115 S.Ct. 1671, 131 L.Ed.2d 695 (1995); *see also Cal. Div. Of Labor Enforcement v. Dillingham Constr.,* 519 U.S. 316, 117 S.Ct. 832, 136 L.Ed.2d 791 (1997); *DeBuono v. NYSA-ILA Med. & Clinical Servs. Fund,* 520 U.S. 806, 117 S.Ct. 1747, 138 L.Ed.2d 21 (1997); *Boggs v. Boggs,* 520 U.S. 833, 117 S.Ct. 1754, 138 L.Ed.2d 45

previously noted, the Supreme Court has returned "to a traditional analysis of preemption, asking if a state regulation frustrated the federal interest in uniformity."[58] Neither the Eighth nor Tenth Circuits operated with the starting assumption that Congress did not intended [sic] to preempt state law in an area of traditional state regulation.[59]

Finally, both parties offer differing accounts of what is "best" in the public's interest. The Hospitals, with support ***541** from the State of Louisiana and amicus curiae AARP and the Louisiana Hospital Association, argue that the assignment statute facilitates delivery of medical treatment to patients, especially low-income patients. To Blue Cross, the assignment statute deprives Blue Cross of a significant carrot-the availability of direct payments. Although recognizing that consumers benefit when Blue Cross pays hospitals directly, Blue Cross uses the availability of direct payments as an important incentive for hospitals to join its provider networks, which requires reduced rates for medical care.

Neither policy choice is absurd, but the preemption inquiry is not resolved by or concerned with arguments of policy. We

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(1997) (applying traditional preemption analysis in concluding state testamentary laws were preempted as applied to an ERISA pension fund).

[58] *Corp. Health Ins., Inc. v. Tx. Dep't of Ins.*, 215 F.3d 526, 533 (5th Cir.2000), *op. mod. and reinstated*, 314 F.3d 784 (5th Cir.2002). This view is in accord with that of other circuits. *See Wright Elec. v. Mn. State Bd. of Elec.*, 322 F.3d 1025, 1029 (8th Cir.2003) (collecting cases).

[59] *St. Mary's Hosp.*, 947 F.2d at 1350 ("We reject St. Mary's argument that preemption is not appropriate because the assignment statute is an exercise of traditional state power .... Although the Supreme Court has not discussed the relevance of this factor, its failure to consider this criterion when deciding ERISA preemption cases is telling." (citing *FMC Corp. v. Holliday*, 498 U.S. 52, 111 S.Ct. 403, 112 L.Ed.2d 356 (1990), and *Mackey*, 486 U.S. 825, 108 S.Ct. 2182, 100 L.Ed.2d 836 (1988)); *St. Francis*, 49 F.3d at 1464 (relying largely on the Eighth Circuit's decision in *St. Mary's Hospital*)).

operate between two conflicting principles: On the one hand, Congress passed ERISA, a comprehensive statute with a "clearly expansive" preemption provision.[60] On the other hand, the Supreme Court requires our analysis to start with the assumption that ERISA was not intended to derogate the historic police powers of the states.[61] The second assumption does not eliminate the first, but we walk a fine line between permissible and impermissible state regulation in this context. As we conclude that Louisiana's assignment statute is not preempted by ERISA, we leave the public policy decision to Louisiana's legislative body. They have chosen assignment of benefit claims over inducing hospitals to enter into Blue Cross's provider networks. Nothing in ERISA requires us to alter that choice.

C

As we conclude that Louisiana's assignment statute is not preempted by ERISA, we need not consider whether the statute is saved from preemption as a law regulating insurance.[62]

III

Accordingly, the district court's judgment is AFFIRMED.
OWEN, Circuit Judge, concurring:

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[60] *See Cal. Div. of Labor Standards Enforcement v. Dillingham Constr.*, 519 U.S. 316, 324, 117 S.Ct. 832, 136 L.Ed.2d 791 (1997) (collecting various descriptions of ERISA's preemption provision).

[61] *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 654-55, 115 S.Ct. 1671, 131 L.Ed.2d 695 (1995).

[62] ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A) ("Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates, insurance, banking, or securities.").

I concur in the judgment. We need not resolve whether section 40:2010 of the Louisiana Revised Statutes "relates to" an employee benefit plan within the meaning of 29 U.S.C. § 1144(a)[1] and the Supreme Court's decisions interpreting and applying that provision. Section 40:2010 is saved from preemption under 29 U.S.C. § 1144(b)(2)(A) as a law that "regulates insurance."[2] Section 40:2010's application to the ERISA benefit plans at issue is accordingly not preempted.

***542** I

Louisiana Health Service & Indemnity Co., doing business as Blue Cross and Blue Shield of Louisiana, insures and administers employee benefit plans that are subject to ERISA. In providing and administering health care benefits, Blue Cross has contracted with hospitals, physicians and others, whom it calls Participating Providers, and agreed to provide direct payment for services rendered to plan beneficiaries. If a plan beneficiary obtains the services of a non-Participating Provider, Blue Cross will reimburse the plan beneficiary but will not make direct payment to the non-Participating Provider. The terms of the ERISA plans that

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[1] That section states:

> Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975. 29 U.S.C. § 1144(a).

[2] *Id.* § 1144(b)(2)(A) ("Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.").

Blue Cross insures or administers are congruent with Blue Cross's method of doing business and provide that assignments by a plan beneficiary to providers other than Participating Providers will not be honored.

I agree with the panel majority that the ERISA plans Blue Cross insures or administers contravene section 40:2010 of the Louisiana Revised Statutes. Section 40:2010 requires insurers to pay benefits directly to a hospital when the insurer has notice that a beneficiary has assigned benefits to that hospital. Section 40:2010 provides:

Not later than ten business days after the date of discharge, each hospital in the state which is licensed by the Department of Health and Hospitals shall have available an itemized statement of billed services for individuals who have received the services from the hospital. The availability of the statement shall be made known to each individual who receives service from the hospital before the individual is discharged from the hospital, and a duplicate copy of the billed services statement shall be presented to each patient within the specified ten day period. No insurance company, employee benefit trust, self-insurance plan, or other entity which is obligated to reimburse the individual or to pay for him or on his behalf the charges for the services rendered by the hospital shall pay those benefits to the individual when the itemized statement submitted to such entity clearly indicates that the individual's rights to those benefits have been assigned to the hospital. When any insurance company, employee benefit trust, self-insurance plan, or other entity has notice of such assignment prior to such payment, any payment to the insured shall not release said entity from liability to the hospital to which the benefits have been assigned, nor shall such payment be a defense to any action by the hospital against that entity to collect the assigned benefits. However, an interim statement shall be

provided when requested by the patient or his authorized agent.[3]

Assuming, *arguendo,* that Blue Cross is correct in contending that the directives in this statute regarding assignments of benefits "relate to" an ERISA employee benefit plan, the Louisiana statute is saved from preemption by the saving clause in 29 U.S.C. § 1144(b)(2)(A). That clause says: "Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities."[4] The ***543** Supreme Court has held that through this saving clause, state laws may indirectly regulate employee benefit plans that are insured.[5] The Court has explained, "an insurance company that insures a plan remains an insurer for purposes of state laws 'purporting to regulate insurance,' " and an "ERISA plan is consequently bound by state insurance regulations insofar as

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[3] La.Rev.Stat. Ann. § 40:2010 (2001).

[4] 29 U.S.C. § 1144(b)(2)(A). Subparagraph B, referenced in this subsection, is the so-called "deemer clause" and provides:

> Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies. *Id.* § 1144(b)(2)(B).

[5] *See FMC Corp. v. Holliday,* 498 U.S. 52, 61, 111 S.Ct. 403, 112 L.Ed.2d 356 (1990) (holding "employee benefit plans that are insured are subject to indirect state insurance regulation"); *Metro. Life Ins. Co. v. Massachusetts,* 471 U.S. 724, 747, 105 S.Ct. 2380, 85 L.Ed.2d 728 (1985) (recognizing "a distinction between insured and uninsured plans, leaving the former open to indirect regulation while the latter are not").

they apply to the plan's insurer."[6] Accordingly, even though the insured employee benefit plans Blue Cross insures or administers[7] may provide that assignments will not be honored, those provisions must give way to state law to the extent ERISA's insurance saving clause applies.[8] It is unnecessary to resolve whether the "deemer" clause, contained in 29 U.S.C. § 1144(b)(2)(B), precludes the application of the ERISA saving clause to self-funded ERISA benefit plans that Blue Cross might administer but not insure because the State of Louisiana concedes that it has not attempted to enforce section 40:2010 with regard to self-funded ERISA plans and Blue Cross does not contend that it administers any self-funded plans to which the State of Louisiana has sought to apply section 40:2010.[9]

Blue Cross does contend, though, that La.Rev.Stat. Ann. § 40:2010 does not "regulate[ ] insurance" within the meaning of ERISA's insurance saving clause. The Supreme Court's decision in *Kentucky Association of Health Plans, Inc. v.*

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[6] *FMC Corp.*, 498 U.S. at 61, 111 S.Ct. 403 (quoting 29 U.S.C. § 1144(b)(2)(B)).

[7] *See Ky. Ass'n of Health Plans, Inc. v. Miller,* 538 U.S. 329, 336 n. 1, 123 S.Ct. 1471, 155 L.Ed.2d 468 (2003) (stating that administration by noninsuring HMO's of even a self-insured plan "suffices to bring them within the activity of insurance for purposes of § 1144(b)(2)(A)").

[8] *See UNUM Life Ins. Co. of Am. v. Ward,* 526 U.S. 358, 375-76, 119 S.Ct. 1380, 143 L.Ed.2d 462 (1999) (rejecting the argument that an ERISA plan's terms always control, observing "insurers could displace any state regulation simply by inserting a contrary term in plan documents" which "would virtually 'rea[d] the saving clause out of ERISA' " (quoting *Metro. Life,* 471 U.S. at 741, 105 S.Ct. 2380)).

[9] *See generally Ky. Ass'n,* 538 U.S. at 336 n. 1, 123 S.Ct. 1471 (discussing the "deemer clause" and the reach of the saving clause when an insurance company or HMO acts only as an administrator of a self-insured ERISA plan); *Rush Prudential HMO, Inc. v. Moran,* 536 U.S. 355, 372 n. 6, 122 S.Ct. 2151, 153 L.Ed.2d 375 (2002) (discussing the possibility that an HMO may provide only administrative services for a self-funded plan and stating that a state law "would not be 'saved' as an insurance law to the extent it applied to self-funded plans").

Miller[10] provides considerable guidance in resolving this question. The Court announced it was "mak[ing] a clean break from the [three] McCarran-Ferguson factors" it had referenced in prior opinions and held "that for a state law to be deemed a 'law ... which regulates insurance' under § 1144(b)(2)(A), it must satisfy two requirements."[11] Those are 1) "the state law must be specifically directed toward entities engaged in insurance" and 2) "the state law must substantially affect the risk ***544** pooling arrangement between the insurer and the insured."[12]

With regard to the first requirement, *Kentucky Association* explained that "laws of general application that have some bearing on insurers do not qualify" as a state law " 'specifically directed toward' the insurance industry,"[13] and "not all state laws 'specifically directed toward' the insurance industry will be covered by § 1144(b)(2)(A)."[14] "[I]nsurers must be regulated 'with respect to their insurance practices.' "[15]

At issue in *Kentucky Association* was a state statute that prohibited health insurers from discriminating against any provider located within the geographic coverage area of a health benefit plan and willing to meet the terms and conditions for participation established by that insurer and a corollary statute that directed that any chiropractor who agreed to the terms, conditions and rates of a health care benefit plan must be permitted to serve as a participating

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[10] 538 U.S. 329, 123 S.Ct. 1471, 155 L.Ed.2d 468 (2003).
[11] *Id.* at 341-42, 123 S.Ct. 1471.
[12] *Id.* at 342, 123 S.Ct. 1471.
[13] *Id.* at 334, 123 S.Ct. 1471 (citing *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 50, 107 S.Ct. 1549, 95 L.Ed.2d 39 (1987)).
[14] Id.
[15] *Id.* (quoting *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 366, 122 S.Ct. 2151, 153 L.Ed.2d 375 (2002)).

primary chiropractic provider.[16] The Supreme Court held that the ERISA saving clause saved these "any-willing-provider" statutes from preemption. The Court reasoned that the statutes " 'regulate[d]' insurance by imposing conditions on the right to engage in the business of insurance." [17]

With regard to the second requirement for application of the insurance saving clause, the Court concluded that the statutes at issue in *Kentucky Association* "substantially affect[ed] the risk pooling arrangement between [the] insurer and [the] insured" because "[b]y expanding the number of providers from whom an insured may receive health services, [any-willing-provider] laws alter the scope of permissible bargains between insurers and insureds."[18] The Court likened the any-willing-provider laws' impact to that of "mandated-benefit laws [it] upheld in *Metropolitan Life,* the notice-prejudice rule [it] sustained in *UNUM,* and the independent-review provisions [it] approved in *Rush Prudential.*"[19]

The Louisiana statute before us is directed toward entities that engage in insurance-"[any] insurance company, employee benefit trust, self-insurance plan, or other entity which is obligated to reimburse the individual or to pay for him or on his behalf the charges for the services rendered by the hospital."[20] The statute's inclusion of "self-insured plans" does not preclude it from qualifying as a law that

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[16] *Id.* at 331-32, 123 S.Ct. 1471.
[17] *Id.* at 338, 123 S.Ct. 1471.
[18] *Id.* at 338-39, 123 S.Ct. 1471.
[19] *Id.* at 339, 123 S.Ct. 1471 (referring to *Metro. Life Ins. Co. v. Massachusetts,* 471 U.S. 724, 105 S.Ct. 2380, 85 L.Ed.2d 728 (1985), *UNUM Life Ins. Co. of Am. v. Ward,* 526 U.S. 358, 119 S.Ct. 1380, 143 L.Ed.2d 462 (1999), and *Rush Prudential HMO, Inc. v. Moran,* 536 U.S. 355, 122 S.Ct. 2151, 153 L.Ed.2d 375 (2002)).
[20] La.Rev.Stat. Ann. § 40:2010.

"regulates insurance."[21] Even benefit plans that are self-funded "engage in the same sort of risk pooling arrangements as separate entities that provide insurance to an employee benefit plan," and in the absence*545 of § 1144(b)(2)(B) (the "deemer clause"), self-funded plans could be regulated by states under the insurance saving clause.[22] The Supreme Court has said, "We do not think [a state law's] application to self-insured non-ERISA plans forfeits its status as a 'law ... which regulates insurance' under 29 U.S.C. § 1144(b)(2)(A)."[23] Likewise, nothing in the text of La.Rev.Stat. Ann. § 40:2010 regarding assignments indicates that the term "other entity which is obligated to reimburse the individual or to pay for him or on his behalf the charges for the services rendered" means anything other than an entity that is engaging is some sort of risk pool arrangement to provide benefits.

The fact that the Louisiana law requiring insurers to honor assignments of benefits to hospitals appears in a statute that also requires hospitals to provide an itemized bill to patients within ten days is of no moment. The provisions that are directed at insurance companies are not directed at hospitals, and mere inclusion of those provisions with other separable regulations does not preclude the provisions aimed at insurers from qualifying as laws "regulat[ing] insurance" under ERISA's insurance saving clause. Nor is it of any

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[21] *See Ky. Ass'n,* 538 U.S. at 336 n. 1, 123 S.Ct. 1471 (discussing the interplay between the insurance saving clause in 29 U.S.C. § 1144(b)(2)(A) and the deemer clause in 29 U.S.C. § 1144(b)(2)(B)).

[22] Id.

[23] *Id.*; see also *Rush Prudential*, 536 U.S. at 372, 122 S.Ct. 2151 (observing that because the "deemer clause" provides an exception to the saving clause, a state law would not be saved under 29 U.S.C. § 1144(2)(b)(A) to the extent is applied to self-funded plans, but nevertheless, "there is no reason to think Congress would have meant such minimal application to noninsurers to remove a state law entirely from the category of insurance regulation").

significance that section 40:2010 is not within Louisiana's insurance code. The State of Louisiana has, through section 40:2010, directly regulated insurance by imposing conditions on the right to engage in the business of insurance in that State.[24]

The Louisiana statute before us satisfies the second requirement identified in *Kentucky Association* as well. Section 40:2010 substantially affects the risk pooling arrangement between the insurer and the insured in much the same way as the state law at issue in *Kentucky Association.* With regard to the any-willing-provider statutes at issue in *Kentucky Association*, the Supreme Court held that those statutes altered the scope of permissible bargains between insurers and insured and observed that Kentucky insureds could "[n]o longer ... seek insurance from a closed network of health-care providers in exchange for a lower premium."[25] Section 40:2010 similarly alters the scope of permissible bargains between insurers and insureds by prohibiting anti-assignment agreements. There is evidence in the record before us that some Louisiana hospitals who were not Participating Providers refused to accept Blue Cross beneficiaries as patients because Blue Cross would not honor patients' assignments of benefits, and Blue Cross would not pay non-Participating Providers directly. Section 40:2010 expands insureds' access to hospitals by removing this obstacle to treatment. Blue Cross must treat all hospitals equally with regard to assignments of benefits. Section 40:2010 also has the effect of requiring insurers like Blue

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[24] *See Ky. Ass'n,* 538 U.S. at 337-38, 123 S.Ct. 1471 (concluding that the any-willing-provider statute at issue regulated insurance and likening the statute to a state law requiring all licensed attorneys to participate in ten hours of continuing legal education, which, the Court said, would be a statute regulating the practice of law).

[25] *Id.* at 339, 123 S.Ct. 1471.

Cross to make allowance for instances in which they erroneously pay a beneficiary directly because payment to the beneficiary is not a defense to the ***546** insurer's obligation to pay the provider.[26] Although Blue Cross might seek to recover an erroneous payment from a beneficiary, some beneficiaries will not have the means, or will refuse, to repay. The unrecoverable costs associated with pursuing beneficiaries paid in error must additionally be taken into account. These considerations have the effect of increasing premiums and spreading the risk of erroneous payments among policyholders.

Section 40:2010 of the Louisiana Revised Statutes is also similar to the statute at issue in *FMC Corp. v. Holliday,* which prohibited insurers from exercising subrogation rights against an insured's tort recovery.[27] The Supreme Court concluded that the anti-subrogation statute would be saved from preemption to the extent that it applied to insured ERISA employee benefit plans, but the statute was preempted to the extent it applied to self-insured plans.[28]

I would hold that ERISA's insurance saving clause applies to La.Rev.Stat. Ann. § 40:2010. The only remaining question is whether section 40:2010 conflicts with ERISA's civil enforcement scheme.

II

Blue Cross contends that section 40:2010 creates a remedy in addition to those set forth in ERISA. That remedy, Blue

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[26] *See* La.Rev.Stat. Ann. § 40:2010 (2001).

[27] 498 U.S. 52, 55 n. 1, 111 S.Ct. 403, 112 L.Ed.2d 356 (1990).

[28] *Id.* at 61, 111 S.Ct. 403 (holding that the state statute "returns the matter of subrogation to state law ... [u]nless the statute is excluded from the reach of the saving clause by virtue of the deemer clause").

Cross contends, is the right to obtain a "double payment" in instances in which Blue Cross has notice of an assignment and pays the beneficiary instead of the hospital to whom the benefits have been assigned. The Supreme Court held in *Aetna Health Inc. v. Davila* that "even a state law that can arguably be characterized as 'regulating insurance' will be preempted if it provides a separate vehicle to assert a claim for benefits outside of, or in addition to, ERISA's remedial scheme." [29]

ERISA's remedial scheme is set forth in 29 U.S.C. § 1132. That section authorizes a participant or beneficiary "to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan."[30] This section "clearly contemplates" that a money judgment may be obtained against benefit plans.[31]

Nothing in ERISA prevents a participant or beneficiary from assigning his or her rights to welfare benefits, which include health care benefits. Notably, ERISA affirmatively prohibits assignment of pension benefits.[32] This distinction led the Supreme Court to conclude that "Congress' decision to remain silent concerning the attachment or garnishment of ERISA welfare plan benefits 'acknowledged and accepted

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[29] 542 U.S. 200, 217-18, 124 S.Ct. 2488, 159 L.Ed.2d 312 (2004).

[30] 29 U.S.C. § 1132(a)(1)(B).

[31] *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 832-33 & n. 7, 108 S.Ct. 2182, 100 L.Ed.2d 836 (1988).

[32] 29 U.S.C. § 1056(d)(1) ("Each pension plan shall provide that benefits provided under the plan may not be assigned or alienated."); *see also Mackey*, 486 U.S. at 836, 108 S.Ct. 2182 (discussing anti-alienation provisions in 29 U.S.C. § 1056(d)(1) and stating, "Congress did not enact any similar provision applicable to ERISA *welfare* benefit plans").

the practice, rather than prohibiting it.' "[33] This Circuit has held that assignees*547 of welfare plan benefits have standing to enforce plan benefits under ERISA.[34]

An assignment of a plan beneficiary's right to receive welfare benefits does nothing more than transfer the right to be paid to the assignee. It does not create new rights outside of ERISA. Blue Cross argues that barring payment to a beneficiary as a defense and requiring payment to an assignee even if payment has been made to the beneficiary creates a new right outside of ERISA's remedial scheme. This contention has no merit. Suppose a plan administrator paid benefits to a former spouse rather than the current spouse of a participant. That mistake would not relieve the plan administrator of its obligation to pay the correct person. The Louisiana statute does not enlarge the rights, causes of action, or remedies of beneficiaries or their assignees. Section 40:2010 simply directs to whom payment must be made once there has been a valid assignment and the plan has received notice of that assignment.

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For the foregoing reasons, I concur in the judgment.

C.A.5 (La.),2006.
Louisiana Health Service & Indem. Co. v. Rapides Healthcare System,
461 F.3d 529, 38 Employee Benefits Cas. 1897

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[33] *Mackey*, 486 U.S. at 837-38, 108 S.Ct. 2182 (quoting *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 516, 101 S.Ct. 1895, 68 L.Ed.2d 402 (1981)).

[34] *Tango Transp. v. Healthcare Fin. Servs. LLC*, 322 F.3d 888, 892 (5th Cir.2003); *see also Hermann Hosp. v. MEBA Med. & Benefits Plan*, 845 F.2d 1286, 1289-90 (5th Cir.1988).

APPENDIX B
RULING AND JUDGMENT OF
THE UNITED STATES DISTRICT COURT,
MIDDLE DISTRICT OF LOUISIANA
OCTOBER 12, 2004

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF LOUISIANA

LOUISIANA HEALTH SERVICE
& INDEMNITY COMPANY d/b/a
BLUE CROSS AND BLUE SHIELD
OF LOUISIANA

CIVIL ACTION

VERSUS

NO. 00-694-D

RAPIDES HEALTHCARE SYSTEM
and STATE OF LOUISIANA, EX REL
RICHARD P. IEYOUB, ATTORNEY
GENERAL FOR THE STATE OF
LOUISIANA **JUDGE BRADY**

RULING ON MOTIONS FOR SUMMARY JUDGMENT

This matter is before the court on a motion for summary judgment (doc. 266) filed by the plaintiff, Louisiana Health Service & Indemnity Company d/b/a Blue Cross and Blue Shield of Louisiana ("Blue Cross").

Also before the court are motions for summary judgment filed by defendant, Rapides Healthcare System ("Rapides"), and intervenor, Dauterive Hospital ("Dauterive") (doc. 263), and by defendant State of Louisiana (doc. 260). Defendants' motions are opposed (doc. 280) and (doc. 282).

Subject matter jurisdiction is based on federal question pursuant to 28 U.S.C. §1331 because the interpretation of the Employee Retirement Income Security Act, 29 U.S.C. §1101, [sic] et seq. ("ERISA") is necessary for resolution of the dispute.

BACKGROUND

The court clearly documented the factual background of this lawsuit in its prior ruling (doc. 102) dated April 15, 2002.[1] There, this court denied Blue Cross's first motion for summary judgment (doc. 50) holding ERISA does not preempt the Louisiana Assignment Statute, La. R.S. 40:2010, as applied to employee benefit plans insured or administered by Blue Cross.

Blue Cross filed the instant motion for summary judgment (doc. 266) again alleging ERISA preempts the provisions of La. R.S. 40:2010 as applied to fully insured employee benefit plans insured or administered by Blue Cross. Blue Cross is seeking to have this court vacate its prior decision and enter judgment in its favor, declaring that ERISA preempts La. R.S. 40:2010 to the extent its enforcement is sought with respect to ERISA plans. Conversely, Defendants argue they are entitled to summary judgment in accordance with the court's ruling on April 15, 2002.

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[1] *See Louisiana Health Serv. & Indem. Co. v. Rapides Healthcare System*, 213 F. Supp. 2d 650 (M.D. La. 2002).

SUMMARY JUDGMENT STANDARD

Summary judgment is appropriate when the pleadings, answers to interrogatories, admissions, and affidavits on file indicate that there is no genuine issue of material fact and that the moving party is entitled to judgment as a matter of law. *See Celotex Corp. v. Catrett*, 477 U.S. 317, 322 (1986). Although this court considers the evidence in the light most favorable to the non-movant, the non-movant may not merely rest on allegations set forth in the pleadings. Instead, the non-movant must show that there is a genuine issue for trial. *See Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248-49 (1986). If, once the non-movant has been given the opportunity to raise a genuine factual issue, no reasonable juror could find for the non-movant, summary judgment will be granted. *See Celotex Corp.*, 477 U.S. at 322; *see also* Fed. Rule Civ. P. 56(c).

ANALYSIS

Blue Cross argues the recent case of *Barber v. UNUM Life Ins. Co. of America*, _____ F.3d _____, 2004 WL 1964500 (3rd Cir. September 7, 2004) is supportive of its argument that ERISA preempts the Louisiana Assignment Statute. The court does not agree with Blue Cross's application of *Barber* to the facts in the present lawsuit.

In *Barber*, the issue was whether ERISA preempted Pennsylvania's bad faith statute for insurance claims. *Id.* at *1. The state statute at issue in *Barber* permitted the plaintiff to seek punitive damages from the defendant for allegedly denying disability benefits in bad faith.

ERISA's exclusive civil enforcement provision permits an ERISA-plan participant to recover benefits, to

obtain a declaratory judgment that he is entitled to benefits, and to enjoin an improper refusal to pay. 29 U.S.C. § 1132(a). Therefore, the Pennsylvania statute permitted a form of recovery (i.e. punitive damages) which was not included in 29 U.S.C. § 1132(a). The Third Circuit found a state statute is preempted by ERISA if it provides a form of ultimate relief in a judicial forum that added to the judicial remedies provided by ERISA. *Id.* at *4. Thus, the court held the Pennsylvania statute was subject to conflict preemption.

However, the Louisiana Assignment Statute is different than the Pennsylvania statute in *Barber*. Specifically, ERISA is silent on the issue of assignability of benefits in insurance plans and the Louisiana statute does not alter an existing ERISA provision. As noted in this court's previous ruling,[2] the Fifth Circuit has specifically found that ERISA permits assignments of health care benefits.[3] Therefore, the court is unpersuaded that the *Barber* decision is applicable in the instant lawsuit. [4]

In accordance with the court's previous ruling,[5] and the aforementioned reasoning, the court finds that the

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[2] *Id.*

[3] *See Hermann v. Hosp. v. MEBA Medical Benefit Plan*, 845 F.2d 1286 (5th Cir. 1988).

[4] Blue Cross accurately states the *Barber* court relied in part on the analysis set forth in *Aetna Health, Inc. v. Davila*, ____ S. Ct. ___, 2004 WL1373230 (June 21, 2004). The state law at issue in *Aetna* permitted claims for failure to exercise ordinary care in the handling of coverage decisions. Thus, the state law conflicted with the notion that individuals who allege they have been denied benefits are restricted to the civil enforcement provisions of ERISA. 29 U.S.C. § 1132(a)(1)(B). The Louisiana Assignment statute is distinguishable from the state law in *Aetna* because the Louisiana law does not alter any existing ERISA provisions.

[5] *See Louisiana Health Serv.*, 213 F. Supp. 2d 650 (M.D. La. 2002).

Louisiana Assignment Statute, La. R.S. 40:2010, is not conflict preempted by ERISA and finds the defendants are entitled to summary judgment.

Accordingly, the motion for summary judgment (doc. 266) filed by the plaintiff, Blue Cross, is hereby DENIED.

Furthermore, the motions for summary judgment (doc. 263) and (doc. 260) filed by defendants, Rapides and the State of Louisiana, are hereby GRANTED.

Baton Rouge, Louisiana, October 12th, 2004.

s/James J. Brady
JAMES J. BRADY, DISTRICT JUDGE
MIDDLE DISTRICT OF LOUISIANA

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF LOUISIANA

LOUISIANA HEALTH SERVICE
& INDEMNITY COMPANY d/b/a
BLUE CROSS AND BLUE SHIELD
OF LOUISIANA

CIVIL ACTION

VERSUS

NO. 00-694-D

RAPIDES HEALTHCARE SYSTEM
and STATE OF LOUISIANA, EX REL.
RICHARD P. IEYOUB, ATTORNEY
GENERAL FOR THE STATE OF
LOUISIANA **JUDGE BRADY**

JUDGMENT

For written reasons assigned,

IT IS ORDERED, ADJUDGED AND DECREED that judgment be entered in favor of the defendants, Rapides Healthcare System and the State of Louisiana, and intervenor, Dauterive Hospital Corp. and against the plaintiff, Blue Cross, and this action is hereby dismissed.

Baton Rouge, Louisiana, October 12th, 2004.

s/James J. Brady
JAMES J. BRADY, DISTRICT JUDGE
MIDDLE DISTRICT OF LOUISIANA

APPENDIX C
DECISION OF
THE UNITED STATES DISTRICT COURT,
MIDDLE DISTRICT OF LOUISIANA
APRIL 15, 2002

United States District Court,
M.D. Louisiana.

LOUISIANA HEALTH SERVICE & INDEMNITY COMPANY d/b/a Blue Cross and Blue Shield of Louisiana,

v.

RAPIDES HEALTHCARE SYSTEM and State of Louisiana, ex rel. Richard P. Ieyoub, Attorney General for the State of Louisiana.

No. Civ.A.00-694-D.

213 F.Supp.2d 650

April 15, 2002.

651 *RULING ON MOTION FOR SUMMARY JUDGMENT

BRADY, District Judge.

This matter is before the court on a motion for summary judgment (doc. 50) filed by the plaintiff, Louisiana Health Service & Indemnity Company d/b/a Blue Cross and Blue Shield of Louisiana ("Blue Cross"). The motion is opposed, and *amicus curiae* briefs have been filed on behalf of the defendants by the Louisiana Department of Insurance and the Louisiana Hospital Association. Subject matter jurisdiction is based on federal question pursuant to 28 U.S.C. § 1331 because the interpretation of the Employee

Retirement Income Security Act, 29 U.S.C. § 1101, [sic] et seq. ("ERISA") is necessary for resolution of the dispute.

Blue Cross filed this lawsuit seeking a declaration that ERISA preempts the provisions of La. R.S. 40:2010 (the "Louisiana Assignment Statute") as applied to employee benefit plans governed by ERISA and insured or administered by Blue Cross. The lawsuit was filed because the Louisiana Department of Insurance, acting upon complaints submitted by defendant Rapides Healthcare System ("Rapides"), had issued findings that health insurance policies issued or administered by Blue Cross violated various state laws, including the Louisiana Assignment Statute. Blue Cross seeks a declaratory judgment based on ERISA's broad preemption provision in order to prevent actions being brought against it for violation of the Louisiana statute.

FACTUAL BACKGROUND

Blue Cross underwrites, provides, and administers various forms of health care service plans for individual and group members who become subscribers. A portion of the health benefit plans that Blue Cross insures and administers are employee welfare benefit plans governed by ERISA. ERISA defines an "employee welfare benefit plan" as one "established or maintained by an employer or by an employee organization" for the purpose of providing employees with "medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, [or] death," whether these benefits are provided "through the purchase of insurance or otherwise." *See* 29 U.S.C. § 1002(1).

As part of its plan administration, Blue Cross enters into individual and group contracts to provide health benefits to

subscribers and also enters into contracts with various health care providers for the provision of health care services to its subscribers. When Blue Cross has a contract with a health care provider that includes a provision allowing for direct payment to the provider, then Blue Cross will make payment directly to that provider. However, Blue Cross' insurance contracts all provide that, in the absence of such an agreement with the provider for direct payment, Blue Cross will pay benefits only to the subscriber (the patient), and it will not recognize the patient's attempted assignment of benefits to the provider. Therefore, Blue Cross will pay a hospital or provider directly only if such hospital or provider has an agreement with Blue Cross for direct payment. Otherwise, Blue Cross will only pay benefits to the patient, and then it is the patient's responsibility to make sure that the provider is paid.

Blue Cross' refusal to recognize certain assignments of benefits by patients is included as a provision in its contracts for health benefit plans, including its ERISA plans. Although ERISA establishes uniform procedural standards concerning reporting, disclosure, and fiduciary responsibility of plan administrators, it does not regulate the substantive content and terms of employee benefit plans. *See* *652 *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 105 S.Ct. 2380, 85 L.Ed.2d 728 (1985). ERISA requires that an employee benefit plan be administered "in accordance with the documents and instruments governing the plan." See 29 U.S.C. § 1104(a)(1)(D). Therefore, Blue Cross argues that, in order to comply with ERISA, it must act in accordance with its ERISA plan provisions and refuse to honor assignments of benefits to providers that do not have a contract with Blue Cross.

However, Blue Cross' refusal to honor assignments is in direct conflict with the Louisiana Assignment Statute, La.

R.S. 40:2010, which requires Blue Cross and other insurers to honor all patients' assignments of benefits, even if the benefits are assigned to a provider that does not have a contract with Blue Cross providing for direct payment. Section 2010, entitled "Itemized statement of billed services by hospitals," appears within Title 40 of the Louisiana Revised Statutes, "Public Health and Safety," Chapter 11, "State Department of Hospitals," Part I, "Organization and Powers," and provides in its entirety:

> Not later than ten business days after the date of discharge, each hospital in the state which is licensed by the Department of Health and Hospitals shall have available an itemized statement of billed services for individuals who have received the services from the hospital. The availability of the statement shall be made known to each individual who receives service from the hospital before the individual is discharged from the hospital, and a duplicate copy of the billed services statement shall be presented to each patient within the specified ten day period. *No insurance company, employee benefit trust, self-insurance plan, or other entity which is obligated to reimburse the individual or to pay for him or on his behalf the charges for the services rendered by the hospital shall pay those benefits to the individual when the itemized statement submitted to such entity clearly indicates that the individual's rights to those benefits have been assigned to the hospital. When any insurance company, employee benefit trust, self-insurance plan, or other entity has notice of such assignment prior to such payment, any payment to the insured shall not release said entity from liability to the hospital to which the benefits have been assigned, nor shall such payment be a defense to any action by the hospital against that entity to collect the assigned benefits.*
>
> However, an interim statement shall be provided when

requested by the patient or his authorized agent. (emphasis added).

The italicized language is the focus of this lawsuit. Blue Cross argues that it cannot comply with both ERISA and La. R.S. 40:2010, and therefore, it asks this court to find that ERISA preempts the provisions of La. R.S. 40:2010 with respect to ERISA plans insured or administered by Blue Cross.

However, the State of Louisiana and Rapides (collectively "the defendants") argue that Blue Cross should not be permitted to violate Louisiana insurance law simply by "uttering the phrase ERISA preemption." They argue that the assignment of insurance benefits has long been a custom and tradition in the insurance industry, respected by insurance companies, protected by the Commissioner of Insurance, and mandated by state law. In fact, Blue Cross honored assignments of insurance benefits up until a little over a year ago. The defendants argue that Blue Cross is now refusing to honor assignments in an effort to punish its insured members who desire the freedom to select their own health care providers, rather than using only health care providers that have a contract with Blue Cross. The *653 defendants assert that ERISA does not preempt the Louisiana Assignment Statute because the Assignment Statute promotes the goals and purpose of ERISA and falls within the scope of state law which Congress never intended ERISA to preempt.

SUMMARY JUDGMENT STANDARD

Summary judgment is appropriate when the pleadings, answers to interrogatories, admissions, and affidavits on file indicate that there is no genuine issue of material fact and that the moving party is entitled to judgment as a matter of

law. *See Celotex Corp. v. Catrett*, 477 U.S. 317, 322, 106 S.Ct. 2548, 91 L.Ed.2d 265 (1986). Although this court considers the evidence in the light most favorable to the non-movant, the non-movant may not merely rest on allegations set forth in the pleadings. Instead, the non-movant must show that there is a genuine issue for trial. *See Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248-49, 106 S.Ct. 2505, 91 L.Ed.2d 202 (1986). If, once the non-movant has been given the opportunity to raise a genuine factual issue, no reasonable juror could find for the non-movant, summary judgment will be granted. *See Celotex Corp.*, 477 U.S. at 322, 106 S.Ct. 2548; *see also* Fed. Rule Civ. P. 56(c).

ANALYSIS

[1] ERISA contains a broad preemption provision declaring that the federal statute "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" covered by ERISA. *See* 29 U.S.C. § 1144(a). Courts have interpreted this preemption clause expansively, observing that it was intended to displace all state laws that fall within its sphere and that its language was designed "to establish ... plan regulation as exclusively a federal concern." *CIGNA Healthplan of Louisiana, Inc. v. State of Louisiana, ex rel. Ieyoub*, 82 F.3d 642, 646 (5th Cir.1996) (quoting *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 138, 111 S.Ct. 478, 482, 112 L.Ed.2d 474 (1990)). The phrase "relate to" has been given a commonsense meaning, and a state law "relates to" an employee benefit plan "in the normal sense of the phrase, if it has a connection with or reference to such a plan." *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96-97, 103 S.Ct. 2890, 77 L.Ed.2d 490 (1983); *Metropolitan Life*, 471 U.S. at 739, 105 S.Ct. 2380. It has repeatedly been held that ERISA preempts state laws that mandate employee benefit structures or their administration. *See New York State Conference of Blue Cross & Blue Shield Plans v. Travelers*

Ins. Co., 514 U.S. 645, 115 S.Ct. 1671, 131 L.Ed.2d 695 (1995); *see also CIGNA Healthplan*, 82 F.3d at 647.

For example, the Fifth Circuit has held that ERISA preempts "any willing provider" statutes, which are statutes mandating that no licensed health care provider who agrees to the terms and conditions of a preferred provider contract shall be denied the right to become a preferred provider. In *CIGNA Healthplan of Louisiana, Inc. v. State of Louisiana, ex rel. Ieyoub*, the Fifth Circuit found that Louisiana's "any willing provider" statute "related to" an ERISA plan because it specifically referred to entities that constituted ERISA-qualified plans and because it mandated the structures of employee benefit plans. *See CIGNA Healthplan*, 82 F.3d at 647-648. ERISA plans that chose to offer coverage by preferred provider organizations (PPOs) were limited by the Louisiana statute to using PPOs of a certain structure, i.e., a structure that included every willing, licensed provider. *Id.* at 648. The court found that the statute mandated that certain benefits available to ERISA plans be constructed in a particular manner, and therefore, the statute delineated the very structure of ERISA plans and impermissibly *654 bound plan administrators to a particular structure. *Id.* at 649.

Blue Cross argues that the Louisiana Assignment Statute attempts to bind it to a particular choice of rules as to how to pay health care benefits. Blue Cross claims that the Assignment Statute commands it to pay benefits in accordance with state law, rather than "in accordance with the documents and instruments governing the plan." Therefore, according to Blue Cross, there is an impermissible conflict between the state law and ERISA, and the state law must be preempted.

Although the Supreme Court has interpreted the language of

ERISA's preemption clause broadly, it has recognized in more recent cases that "the term 'relate to' cannot be taken 'to extend to the furthest stretch of its indeterminacy,' or else 'for all practical purposes preemption would never run its course.' " *Egelhoff v. Egelhoff, ex rel. Breiner*, 532 U.S. 141, 121 S.Ct. 1322, 149 L.Ed.2d 264 (2001); *Travelers*, 514 U.S. at 655, 115 S.Ct. 1671. The Court has found that some state laws may affect employee benefit plans in too tenuous, remote, or peripheral a manner to justify a finding that the law "relates to" the plan. *See CIGNA Healthplan*, 82 F.3d at 647; *see also Shaw*, 463 U.S. at 100, 103 S.Ct. 2890. The defendants argue that, in a trilogy of recent cases,[1] the Supreme Court has begun to move away from a broad reading of ERISA's preemption clause and toward a more traditional analysis of preemption.

For example, in the first of the three cases, a unanimous Supreme Court held that ERISA does not preempt state laws that have only an indirect economic effect on the relative costs of various health insurance packages available to ERISA-qualified plans. *See Travelers*, 514 U.S. at 668, 115 S.Ct. 1671. This is because an indirect economic influence does not bind plan administrators to any particular choice, and therefore, it does not function as a regulation of an ERISA plan itself. *Id.* at 659, 115 S.Ct. 1671.

The defendants argue that, with these three cases, the Supreme Court has begun to narrow the broad scope of ERISA preemption. They point out that in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers*

---

[1] *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 115 S.Ct. 1671, 131 L.Ed.2d 695 (1995); *California Division of Labor Standards Enforcement v. Dillingham Construction, N.A.*, Inc., 519 U.S. 316, 117 S.Ct. 832, 136 L.Ed.2d 791 (1997); *De Buono v. NYSA-ILA Medical and Clinical Services Fund*, 520 U.S. 806, 117 S.Ct. 1747, 138 L.Ed.2d 21 (1997).

Ins. Co., the Supreme Court noted that it never assumes lightly that Congress has derogated state regulation, but instead begins with the presumption that Congress does not intend to supplant state law. *Id.* at 654, 115 S.Ct. 1671. The Court further stated that, in areas of traditional state regulation, it works on the "assumption that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress." *Id.* at 654, 115 S.Ct. 1671. The Court also recognized that, in determining whether a state law has a forbidden connection with ERISA plans, it is necessary to go beyond the unhelpful text of the preemption clause and look instead to "the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive, as well as to the nature of the effect of the state law on ERISA plans." *Egelhoff*, 532 U.S. at 147, 121 S.Ct. 1322; *Travelers*, 514 U.S. at 656, 115 S.Ct. 1671.

[2][3] The defendants argue that, instead of applying an all encompassing and *655 unrestricted rule of preemption, courts should consider the intent and purpose of ERISA and the specific facts of the case to determine whether a state law relates to an ERISA plan in some way and whether it should be deemed preempted because of an impermissible interference with the scheme of the ERISA statute. This court agrees with the defendants. One of Congress' goals in enacting ERISA was to enhance the health and welfare benefits of employees, and the Louisiana Assignment Statute should not be preempted because it does not interfere with this goal but, in fact, facilitates it. The Fifth Circuit has specifically recognized that an assignment of benefits to a health care provider facilitates rather than hampers the employee's receipt of health benefits. *See Hermann Hosp. v. MEBA Medical & Benefits Plan*, 845 F.2d 1286 (5th Cir.1988). First of all, it keeps the employee from having to pay health care costs up front out of his own pocket.

Furthermore, health care providers are better equipped and financed to pursue an action for the payment of benefits. The honoring of benefit assignments to health care providers promotes efficiency in plan administration by streamlining the claims process and removing the patients from the payment process.

Not only does the Louisiana Assignment Statute facilitate and promote the goals of ERISA, it also constitutes a general health care regulation and is within the scope of state law that Congress did not intend ERISA to preempt. The Supreme Court has stated that general health care regulation has historically been a matter of local concern and that there is nothing in the language of ERISA to indicate that Congress intended to displace such general health care regulation. *See Travelers*, 514 U.S. at 661, 115 S.Ct. 1671. In fact, ERISA is completely silent on the issue of the assignability of benefits in insurance plans. ERISA specifically sets forth a prohibition against the assignment of employee pension benefits, but Congress chose not to include a parallel bar against the assignability of health care benefits. Congress' silence on the issue of the assignability of health care benefits gives rise to an inference that Congress intended to treat such benefits differently, and that Congress does not intend to enact a policy precluding their assignability. *See Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 836-37, 108 S.Ct. 2182, 100 L.Ed.2d 836 (1988); *see also Hermann Hosp.*, 845 F.2d at 1289.

Based on Congress' decision to remain silent on the issue, the Fifth Circuit has specifically found that ERISA permits assignments of health care benefits. *Hermann Hosp.*, 845 F.2d at 1289. Therefore, there is no conflict between ERISA and the Louisiana Assignment Statute. ERISA's silence on the issue of the assignability of health care benefits indicates

that Congress intended to allow the states to make their own decisions regarding assignability.

Blue Cross points out that other circuits have refused to interpret ERISA's silence on the issue of assignability of health care benefits as an invitation to the states to adopt their own rules pertaining to assignability. *City of Hope National Medical Center v. Healthplus, Inc.*, 156 F.3d 223, 229 (1st Cir.1998); *St. Francis Regional Medical Center v. Blue Cross & Blue Shield of Kansas*, 49 F.3d 1460, 1464 (10th Cir.1995). Instead, they interpret ERISA's silence as leaving the assignability of benefits to the free negotiations and agreement of the contracting parties. However, this court does not subscribe to the reasoning espoused by those circuits. The assignability of health care benefits has historically been a matter of local concern, and this court finds that Congress did not intend for ERISA to preempt state laws concerning assignability. Congress' *656 silence on the issue, when considered along with the goals and objectives of ERISA, indicates that the Louisiana Assignment Statute should not be preempted by ERISA.

Blue Cross also argues that a recent Supreme Court case, *Egelhoff v. Egelhoff*, mandates a finding of ERISA preemption in the instant case. At issue in *Egelhoff* was a Washington statute that provided that the designation of a spouse as the beneficiary of a nonprobate asset (which included employee benefit plans) would be automatically revoked upon divorce. *Egelhoff v. Egelhoff, ex rel. Breiner*, 532 U.S. 141, 121 S.Ct. 1322, 149 L.Ed.2d 264 (2001). The Supreme Court held that ERISA preempted the state beneficiary designation statute to the extent it applied to ERISA plans. *Id.* at 147, 121 S.Ct. 1322. The statute required ERISA plan administrators to pay beneficiaries chosen by state law, rather than the beneficiaries identified in the plan documents. Therefore, the Court concluded that the

statute had an impermissible connection with ERISA plans because it bound plan administrators to a particular choice of rules for determining beneficiary status. *Id.* at 147, 121 S.Ct. 1322.

Blue Cross asserts that the Louisiana Assignment Statute, like the statute at issue in *Egelhoff*, purports to bind an ERISA plan administrator to a particular choice of rules concerning the payment of benefits. However, this court does not agree and instead finds that *Egelhoff* does not require a finding of preemption in this case. In *Egelhoff*, the Court found that the state statute was preempted because it violated ERISA's requirement that the plan be administered "in accordance with the documents and instruments governing the plan," making payments to a "beneficiary" who is "designated by a participant, or by the terms of [the] plan." *Id.* at 147, 121 S.Ct. 1322; *see also* 29 U.S.C. § 1104(a)(1)(D); *see also* 29 U.S.C. § 1002(8). The Washington statute at issue in *Egelhoff* provided that a plan participant's designation of a beneficiary would automatically be invalidated by operation of state law, without any affirmative act by the participant, and in spite of any existing designation in the documents and instruments governing the plan. Therefore, the statute effectively allowed the state of Washington to designate the beneficiary to receive plan benefits, in contravention of ERISA.

However, the Louisiana Assignment Statute is different because it does not invalidate, revoke, or alter a plan participant's designation of a beneficiary. A "beneficiary" is "a person [2] designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder." *See* 29 U.S.C. § 1002(8). An assignment of benefits is a designation of a beneficiary by a

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[2] Under 29 U.S.C. § 1002(9), the term "person" includes natural persons and juridical persons such as corporations and other entities.

plan participant as contemplated by ERISA's definition of "beneficiary." This is because a participant's assignment of benefits to his health care provider makes the assignee a person who is "entitled to a benefit" under the plan. *Kennedy v. Connecticut General Life Ins. Co.*, 924 F.2d 698, 700 (7th Cir.1991). Such a designation is expressly permitted by ERISA. The Louisiana Assignment Statute only becomes applicable when a plan participant has made such an affirmative designation, through the assignment of his benefits. Therefore, the statute does not allow the state of Louisiana to designate the beneficiary, as occurred in *Egelhoff*, but rather the Assignment Statute honors a designation made by a participant, as expressly contemplated by ERISA.

*657 Because ERISA already requires Blue Cross, as a plan administrator, to make payments to a beneficiary designated by a plan participant, the Louisiana Assignment Statute does not conflict with ERISA. At most, the statute has only an indirect economic effect on ERISA plans because it takes away some of Blue Cross' bargaining power when negotiating to attract new health care providers to join its network. Such an indirect economic effect is not sufficient to justify a finding that the statute "relates to" an ERISA plan. See *Travelers*, 514 U.S. at 668, 115 S.Ct. 1671.

Therefore, after considering the intent and purpose of ERISA as well as the nature of the effect that the Louisiana Assignment Statute has on ERISA plans, the court finds that ERISA does not preempt the Louisiana Assignment Statute, La. R.S. 40:2010, as applied to employee benefit plans insured or administered by Blue Cross.

Furthermore, the court finds that the language of Blue Cross' health care plans requires that Blue Cross honor a patient's assignment of benefits. This is because the anti-assignment

provisions in the Blue Cross plans state that assignments of benefits will not be honored "except as required by law." ERISA is silent on the issue of assignment of health care benefits, and therefore, "except as required by law" must necessarily refer to requirements of state law, including Louisiana's requirement in La. R.S. 40:2010 that assignments of benefits are honored.

Moreover, Blue Cross' policies issued in Louisiana contain a clause providing that any policy term that conflicts with state law is amended to conform to state law. As a result, Blue Cross' anti-assignment provision is automatically amended, by the terms of the policy, to conform to the requirements of the Louisiana Assignment Statute, and Blue Cross is required to honor assignments of benefits.

Accordingly, the motion for summary judgment (doc. 50) filed by the plaintiff, Louisiana Health Service & Indemnity Company d/b/a Blue Cross and Blue Shield of Louisiana, is hereby DENIED.

APPENDIX D
ORDER OF THE
UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT
DENYING PETITION FOR REHEARING *EN BANC*
SEPTEMBER 15, 2006

UNITED STATES COURT OF APPEALS

FOR THE FIFTH CIRCUIT

No. 04-31114

LOUISIANA HEALTH SERVICES & INDEMNITY CO., doing business as Blue Cross Blue Shield of Louisiana

Plaintiff - Intervenor Defendant - Appellant

v.

RAPIDES HEALTHCARE SYSTEM; STATE OF LOUISIANA; CHARLES R FOTI JR, Attorney General for the State of Louisiana;

Defendants - Appellees

v.

DAUTERIVE HOSPITAL

Intervenor Plaintiff - Appellee

Appeal from the United States District Court for the Middle District of Louisiana, Baton Rouge.

ON PETITION FOR REHEARING EN BANC

(Opinion 8/16/06, 5 Cir., _____, _____ F. 3d _____)

Before HIGGENBOTHAM, DeMOSS, and OWEN, Circuit Judges.

PER CURIAM:

(X) Treating the Petition for Rehearing En Banc as a Petition for Panel Rehearing, the Petition for Panel Rehearing is DENIED. No member of the panel nor judge in regular active service of the court having requested that the court be polled on Rehearing En Banc (FED. R. App. P. and 5th CIR. R. 35), the Petition for Rehearing En Banc is DENIED.

( ) Treating the Petition for Rehearing En Banc as a Petition for Panel Rehearing, the Petition for Rehearing is DENIED. The court having been polled at the request of one of the member of the court and a majority of the judges who are in regular active service and not disqualified not having voted in favor (FED. R. APP. P. and 5th CIR. R. 35), the Petition for Rehearing En Banc is DENIED.

ENTERED FOR THE COURT

/s/ Higginbotham
United States Circuit Judge

APPENDIX E
JUDGMENT OF THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT, ISSUED AS MANDATE SEPTEMBER 25, 2006

UNITED STATES COURT OF APPEALS

FOR THE FIFTH CIRCUIT

No. 04-31114

Docket No. 3:00-CV-694-D

LOUISIANA HEALTH SERVICES & INDEMNITY CO., doing business as Blue Cross Blue Shield of Louisiana

Plaintiff - Intervenor Defendant - Appellant

v.

RAPIDES HEALTHCARE SYSTEM; STATE OF LOUISIANA; CHARLES R FOTI JR, Attorney General for the State of Louisiana;

Defendants - Appellees

v.

DAUTERIVE HOSPITAL

Intervenor Plaintiff - Appellee

Appeal from the United States District Court for the Middle District of Louisiana, Baton Rouge.

Before HIGGINBOTHAM, DeMOSS, and OWEN, Circuit Judges.

JUDGMENT

This cause was considered on the record on appeal and was argued by counsel.

It is ordered and adjudged that the judgment of the District Court is affirmed.

IT IS FURTHER ORDERED that appellant pay to appellees the costs on appeal to be taxed by the Clerk of this Court.

OWEN, Circuit Judge, concurs.

ISSUED AS MANDATE: SEP 25 2006

APPENDIX F
UNITED STATES CONSTITUTION, ARTICLE VI, CLAUSE 2

This Constitution, and the laws of the United States which shall be made in pursuance thereof; and all treaties made, or which shall be made, under the authority of the United States, shall be the supreme law of the land; and the Judges in every State shall be bound thereby, anything in the Constitution or laws of any State to the contrary notwithstanding.

APPENDIX G
ERISA PROVISIONS

29 U.S.C. § 1002. Definitions

For purposes of this subchapter:

. . . . (8) The term "beneficiary" means a person designated by a participant, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder.

. . . .

---

29 U.S.C. § 1102. Establishment of plan

(a) Named fiduciaries

(1) Every employee benefit plan shall be established and maintained pursuant to a written instrument.

. . . .

(b) Requisite features of plan

Every employee benefit plan shall--

. . . . (4) specify the basis on which payments are made to and from the plan.

29 U.S.C. § 1104. Fiduciary duties

(a) Prudent man standard of care

(1) Subject to sections 1103(c) and (d), 1342, and 1344 of this title, a fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and--

. . . .

(D) in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with the provisions of this subchapter and subchapter III of this chapter.

---

29 U.S.C. § 1132. Civil enforcement

(a) Persons empowered to bring a civil action

A civil action may be brought--

(1) by a participant or beneficiary--

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

(2) by the Secretary, or by a participant, beneficiary or

fiduciary for appropriate relief under section 1109 of this title;

(3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan;

. . . .

(e) Jurisdiction

(1) Except for actions under subsection (a)(1)(B) of this section, the district courts of the United States shall have exclusive jurisdiction of civil actions under this subchapter brought by the Secretary or by a participant, beneficiary, fiduciary, or any person referred to in section 1021(f)(1) of this title. State courts of competent jurisdiction and district courts of the United States shall have concurrent jurisdiction of actions under paragraphs (1)(B) and (7) of subsection (a) of this section.

. . . .

(f) Amount in controversy; citizenship of parties

The district courts of the United States shall have jurisdiction, without respect to the amount in controversy or the citizenship of the parties, to grant the relief provided for in subsection (a) of this section in any action.

(g) Attorney's fees and costs; awards in actions involving delinquent contributions

(1) In any action under this subchapter (other than an action described in paragraph (2)) by a participant, beneficiary, or fiduciary, the court in its discretion may allow a reasonable attorney's fee and costs of action to either party.

. . . .

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29 U.S.C. § 1144. Other laws

(a) Supersedure; effective date

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

(b) Construction and application

(1) This section shall not apply with respect to any cause of action which arose, or any act or omission which occurred, before January 1, 1975.

(2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust

established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

. . . .

APPENDIX H
LA. REV. STAT. ANN. § 40:2010

LOUISIANA REVISED STATUTES
TITLE 40. PUBLIC HEALTH AND SAFETY
CHAPTER 11. STATE DEPARTMENT OF HOSPITALS
PART I. ORGANIZATION AND POWERS

§ 2010. Itemized statement of billed services by hospitals

Not later than ten business days after the date of discharge, each hospital in the state which is licensed by the Department of Health and Hospitals shall have available an itemized statement of billed services for individuals who have received the services from the hospital. The availability of the statement shall be made known to each individual who receives service from the hospital before the individual is discharged from the hospital, and a duplicate copy of the billed services statement shall be presented to each patient within the specified ten day period. No insurance company, employee benefit trust, self-insurance plan, or other entity which is obligated to reimburse the individual or to pay for him or on his behalf the charges for the services rendered by the hospital shall pay those benefits to the individual when the itemized statement submitted to such entity clearly indicates that the individual's rights to those benefits have been assigned to the hospital. When any insurance company, employee benefit trust, self-insurance plan, or other entity has notice of such assignment prior to such payment, any payment to the insured shall not release said entity from liability to the hospital to which the benefits have been assigned, nor shall such payment be a defense to any action by the hospital against that entity to collect the assigned benefits. However, an interim statement shall be provided when requested by the patient or his authorized agent.

APPENDIX I
BLUE CROSS SAMPLE PLAN EXCERPT: DIRECT PAYMENT PROVISION

Direct Payment to Member

1. All benefits payable by the Company under this Benefit Plan and any amendment hereto are personal to the Member and are not assignable in whole or in part by the Member. The Company has the right to make payment to a Hospital, Physician, or other Provider (instead of to the Member) for Covered Services which they provide while there is in effect between the Company and any such Hospital, Physician, or other Provider an agreement calling for the Company to make payment directly to them. In the absence of such an agreement for direct payment, the Company will pay to the Member and only the Member those Benefits called for herein and the Company will not recognize a member's attempted assignment to, or direction to pay, another, except as required by law.

2. Hospitals, Physicians, and other Providers which have agreed with the Company or another Blue Cross and Blue Shield Benefit Plan for such direct payment are, by reason of such agreements, "Participating Hospitals," "Participating Physicians" (often called "Key Physicians"), or "Participating other Providers," respectively, and are referred to collectively as "Participating Providers." Those Hospitals, Physicians, and other Providers which do not have such agreements for direct payment are "Nonparticipating Hospitals," "Nonparticipating Physicians," and "Nonparticipating other Providers," respectively, and are referred to collectively as "Nonparticipating Providers."

3. If the Company has offered a Hospital, Physician, or other Provider an agreement for direct payment by the Company, but there is no such arrangement in effect when Covered Services are rendered to a Member by such Hospital, Physician, or other Provider, the Company will not recognize a Member's attempted assignment to, or direction to pay, such Hospital, Physician, or other Provider. The Company will pay to the Member and only the Member those Benefits called for in this Benefit Plan and any amendment thereto.

(4)

No. 06-839

FILED
FEB 16 2007
OFFICE OF THE CLERK
SUPREME COURT, U.S.

IN THE
Supreme Court of the United States

LOUISIANA HEALTH SERVICE & INDEMNITY CO.,
doing business as Blue Cross and Blue Shield of Louisiana,
Petitioner

v.

RAPIDES HEALTHCARE SYSTEM, STATE OF LOUISIANA,
ex. rel. CHARLES R. FOTI, JR., Attorney General
for the State of Louisiana, and DAUTERIVE HOSPITAL,
Respondents

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

STATE OF LOUISIANA'S OPPOSITION BRIEF

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IN THE
SUPREME COURT OF THE UNITED STATES

STATE OF LOUISIANA'S OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

Respondent the State of Louisiana, *ex rel.* Charles C. Foti, Jr., Attorney General for the State of Louisiana ("the State"), respectfully submits that the petition for a writ of certiorari to review the judgment of the United States Court of Appeals for the Fifth Circuit, filed by Petitioner Louisiana Health Service & Indemnity Co., d/b/a Blue Cross and Blue Shield of Louisiana ("Blue Cross"), should be denied.

As a matter of judicial efficiency and to avoid the Court's review of duplicative arguments, the State hereby adopts the opposition brief filed by Respondent Rapides Healthcare Services and requests that the Court deny Blue Cross's petition for a writ of certiorari for the reasons discussed therein, as well as for the reasons upon which the United States Fifth Circuit Court of Appeal based its judgment in this matter. *See Louisiana Health Service & Indemnity Co. v. Rapides Healthcare System*, 461 F.3d 529 (5th Cir. 2006).

CONCLUSION

The State respectfully prays that the Court deny the petition for a writ of certiorari filed by Blue Cross.

Respectfully submitted,

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IN THE
Supreme Court of the United States

LOUISIANA HEALTH SERVICE & INDEMNITY CO., doing business as Blue Cross and Blue Shield of Louisiana,
Petitioner,

v.

RAPIDES HEALTHCARE SYSTEM; STATE OF LOUISIANA; CHARLES R. FOTI, JR., Attorney General for the State of Louisiana; DAUTERIVE HOSPITAL,
Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

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QUESTIONS PRESENTED

1. Whether the Louisiana Assignment Statute, Louisiana Revised Statute § 40:2010, is expressly preempted by Section 514(a) of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1144(a).

2. Whether the Louisiana Assignment Statute duplicates or otherwise conflicts with the cause of action for benefits set forth in ERISA Section 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B).

RULE 29.6 STATEMENT

Pursuant to Rule 29.6, Respondents Rapides Healthcare System and Dauterive Hospital state the following:

Rapides Healthcare System, L.L.C. is 75 % owned by (1) Galen Holdco, L.L.C. (66.77%), which owns Rapides' parent corporations, the Galen Virginia Hospital Corporation, WGH, Inc., Extendicare Properties, Inc., Columbia/HCA Healthcare Corporation of Central Louisiana, and Galen LA, L.L.C., and (2) Galen LA, L.L.C. (7.23%). Galen Holdco, L.L.C. and Galen LA, L.L.C. are the wholly-owned subsidiaries of Healthtrust, Inc.-The Hospital Company. Healthtrust, Inc.-The Hospital Company is a wholly-owned subsidiary of HCA, Inc. a privately-held corporation. The Rapides Foundation, a tax-exempt not-for-profit corporation, owns the remaining 26% of Rapides Healthcare system, L.L.C.

Dauterive Hospital is wholly owned by the Dauterive Hospital Corporation which, through its parent HTI Hospital Holdings, Inc., and grandparent Healthtrust, Inc.-The Hospital Company is a wholly-owned subsidiary of HCA Inc.

An ownership of more than 10% in both Dauterive Hospital and the Rapides Healthcare System is held by Merrill Lynch & Co., Inc., a publicly-traded company.

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STATEMENT OF THE CASE

The Louisiana Assignment Statute, codified at Louisiana Revised Statute § 40:2010 ("Assignment Statute"), regulates the health insurance claims process by requiring that all entities indemnifying a patient for health care expenses honor the patient's assignment of heath care benefits to a hospital. Consistent with the aims of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001, *et seq.*, the Assignment Statute thus facilitates employees' receipt of their welfare benefits by removing an unnecessary middleman (the patient) from the claims process. Refusing to honor assignments inflicts a deadweight loss on the entire health care system by forcing the provider to pursue a separate claim against the patient, who may be unwilling or unqualified to pursue the insurance benefits to which he or she is entitled, or simply reluctant to turn them over to the hospital after collecting them.

The Petitioner, Louisiana Health Service & Indemnity Company d/b/a Blue Cross and Blue Shield of Louisiana ("Blue Cross"), has no legitimate interest in imposing those costs on patients or the system, but wants to brandish the threat to increase its leverage in negotiations with hospitals. If Blue Cross wants to incentivize hospitals to join its network, it can do so by limiting coverage or reimbursement rates for out-of-network care. Blue Cross knows its own insureds would react badly to those moves, and simply wants to coerce providers into network so that it can lower its own reimbursement payments in a way that its insureds will not notice or understand. That tactic serves no public interest.

The Fifth Circuit correctly held that the Assignment Statute is fully consistent with the text and purposes of ERISA, and is not preempted. That decision does not conflict with any decision of this Court or of any other Circuit. The Petition should be denied.

Factual Background

Rapides Healthcare System ("Rapides") is a community health care system based in Alexandria, Louisiana,

operating hospitals throughout central Louisiana. Dauterive Hospital ("Dauterive") is a community hospital located in New Iberia, Louisiana. R. 9:1588-92. Both Rapides and Dauterive (the "Hospitals") serve patients who are covered by ERISA and non-ERISA policies and plans insured or administered by Blue Cross. *Id.*

In lieu of advance payment, the Hospitals routinely accept assignments of benefits from their patients, including patients insured by Blue Cross. R. 9:1590. The Louisiana Assignment Statute builds on the insurance claims process utilized by every insurer in the state and throughout the country. Under that process, a hospital notifies an insurer on the National Uniform Bill (today, termed a UB-92), which it submits on the patient's behalf. La. Rev. Stat. Ann. §§ 22:213(A)(14), 22:214.3(A). That form includes a space for the hospital to notify the insurer of an assignment.

For many years, while the Hospitals were considered "in network," Blue Cross accepted the electronic submission of the Hospitals' claims on the National Uniform Bill, including the notification of assignments of benefits, and paid assigned benefits directly to the Hospitals. R. 6:1012-13, 1015. In October of 1999, however, after lengthy but unsuccessful negotiations regarding reimbursement rates, Rapides terminated its Network Provider Agreement with Blue Cross. R. 6:1015. Despite the contract's termination, Rapides continued to treat patients covered by Blue Cross plans, and continued to accept assignments of benefits from those patients. R. 2:327-28. Although Blue Cross continued to accept the electronic submission of claims for benefits on the National Uniform Bill from Rapides, it refused to honor assignments of benefits to Rapides. R. 9:1589.

In October of 2000, after similarly unsuccessful negotiations with Blue Cross regarding rates of reimbursement, Dauterive also terminated its Network Provider Agreement. R. 6:105. Like Rapides, Dauterive continued to treat patients covered by policies and plans insured or administered by Blue Cross, continued to accept assignments of benefits, and continued to submit claims to

Blue Cross electronically on the Uniform Bill, as it had for years. R. 6:1013, 1015. As with Rapides, Blue Cross refused to honor the assignments of benefits to Dauterive and instead paid the claimed benefits directly to participants and insureds. R. 6:1012.

Blue Cross contended that the anti-assignment provisions contained in the plan documents and policies it drafted required it to refuse to honor the assignments of benefits. Pet. 41a. Blue Cross sent benefit checks for services performed by the Hospitals, often for thousands of dollars, directly to plan beneficiaries rather than to the Hospitals themselves. R. 6:1012. On virtually every claim, Blue Cross also paid a benefit to the patient of less than the amount the Hospital billed. R. 6:1010. In many cases, the patients did not remit any of their reimbursement amounts to the Hospitals. *Id.* Consequently, the Hospitals were forced to pursue payment from their patients directly through hundreds of collection lawsuits, garnishments, and seizures of assets. R. 9:1566.

Rapides, and later Dauterive, filed complaints with the Louisiana Department of Insurance ("DOI") concerning Blue Cross's business practices, including its refusal to honor its members' assignments of benefits. R. 2:357-81. In response, the DOI opened an investigation of Blue Cross's claims processing practices and on July 14, 2000, issued a show cause letter to Blue Cross regarding its refusal to honor assignments of benefits in violation of La. Rev. Stat. Ann. § 40:2010. R. 2:356. In response, Blue Cross filed this suit.

Proceedings Below

1. On September 14, 2000, Blue Cross filed a Complaint for Declaratory Relief against Rapides and the State of Louisiana, seeking a declaration that ERISA preempts the Louisiana Assignment Statute. R. 1:1-7. Rapides filed counterclaims against Blue Cross seeking recovery of benefits owed for services rendered to patients covered by ERISA and non-ERISA policies and plans insured or administered by Blue Cross. R. 2:190-200. On August 6,

2001, Dauterive intervened in the suit and alleged claims similar to those asserted by Rapides. R. 2:266-78.

On August 13, 2001, Blue Cross filed a motion for summary judgment seeking a declaration that ERISA preempted the Assignment Statute. R. 2:279-81. On April 15, 2002, the district court denied Blue Cross's motion and found that ERISA did not expressly preempt the Assignment Statute. R. 4:624-39 (*La. Health Serv. & Indem. Co. v. Rapides Healthcare Sys.*, 213 F. Supp. 2d 650 (M.D. La. 2002)). The district court agreed with the Hospitals that this Court's jurisprudence required it to "consider the intent and purpose of ERISA," and whether the statute was consistent with those goals. Pet. App. 47a. The court found that "[o]ne of Congress' goals in enacting ERISA was to enhance the health and welfare benefits of employees, and the Louisiana Assignment Statute should not be preempted because it does not interfere with this goal but ... facilitates it." *Id.* The district court then expressly recognized that the statute "constitute[d] a general health care regulation and is within the scope of state law that Congress did not intend ERISA to preempt," *Id.* at 48a. Finding that the statute had "[a]t most, ... an indirect economic effect on ERISA plans," the court concluded that such an effect is "not sufficient to justify a finding that the statute 'relates to' an ERISA plan" and denied Blue Cross's motion for summary judgment. *Id.*

For the next sixteen months, the parties litigated the antitrust, ERISA, and state law claims for damages. In January of 2004, the Hospitals and Blue Cross agreed to settle the parties' damages claims. *Id.* at 5a, R. 8:1529. In conjunction with the settlement, the Hospitals re-entered Blue Cross's provider network. The parties could not resolve the ERISA preemption issue and presented it to the district court for determination. R. 9:1650-53, 1662-63.

On June 17, 2004 the parties filed cross motions for summary judgment. R. 8:1540-42; 9:1585-87, 1645-47. The substance of the motions was largely the same as before, although Blue Cross added a new argument based on

complete preemption in light of this Court's decision in *Aetna Health Inc. v. Davila*, 542 U.S. 200 (2004). R. 9:1715-19. On October 12, 2004, the district court reaffirmed its prior ruling and rejected Blue Cross's complete preemption argument. R. 10:1820-25.

2. On appeal, the Fifth Circuit affirmed. *La. Health Serv. & Indem. Co. v. Rapides Healthcare Sys.*, 461 F.3d 529 (5th Cir. 2006) (Pet. App. 21a). The court began by rejecting Blue Cross's newly-minted argument that *Davila* required a finding of complete preemption because the statute "duplicates, supplements, or supplants" ERISA's exclusive remedies. The Fifth Circuit found the Louisiana statute was "readily distinguishable" from the state law in *Davila* that created a cause of action for the denial of ERISA benefits. Pet. App. 9a. The court explained that the Assignment Statute did not create a new cause of action, but merely provided for the assignment of the cause of action to recover plan benefits created by ERISA itself. *Id.* at 10a. The court was not persuaded that the Assignment Statute required Blue Cross to pay the same benefits twice, reasoning that so long as Blue Cross complies with the assignments, it will only be required to pay once. *Id.* at 11a.

On the express preemption question, the Fifth Circuit held that the Louisiana statute did not "relate to" an ERISA plan. Applying this Court's recent precedents, the court of appeals "start[ed] with the assumption that 'the historic police powers of the States were not to be superseded by [ERISA] unless that was the clear and manifest purpose of Congress.'" *Id.* at 13a. (citation omitted) (alteration in original). It then explained that the Assignment Statute was a traditional exercise of state power in the area of health and welfare, and was fully consistent with ERISA's goals and policies.

The Fifth Circuit rejected Blue Cross's claim that this Court's decision in *Egelhoff v. Egelhoff*, 532 U.S. 141 (2001), required a finding of preemption. Unlike the Washington statute in *Egelhoff*, which required payment to a person designated by state law despite the beneficiary's own

designation, the court reasoned the Assignment Statute "is consistent with the express terms of ERISA—leaving the beneficiary determination to *either* the person designated by the participant or the person designated by the plan." Pet. App. 17a. And unlike the statute in *Egelhoff*, the court held, the Assignment Statute would not "impermissibly interfere with nationally uniform plan administration" because it actually reduces paperwork and lessens the burden on insurers. *Id.* at 17a-18a.

The Fifth Circuit acknowledged that the Eighth and Tenth Circuits had concluded that ERISA preempted different state assignment statutes, but held that those decisions were both distinguishable and unpersuasive in light of intervening Supreme Court precedent. *Id.* at 18a. Because the Eighth and Tenth Circuit cases were decided "prior to the Supreme Court's rejection ... of an 'uncritical literalism' in the application of ERISA's 'unhelpful text,'" *id.* at 19a (citation omitted), neither case "operated with the starting assumption that Congress did not intend[] to preempt state law in an area of traditional state regulation." *Id.* at 20a. Finding that Blue Cross failed to overcome that presumption, the court held that ERISA did not expressly preempt the Assignment Statute. As a result, the Fifth Circuit did "not consider whether the statute is saved from preemption as a law regulating insurance." *Id.* at 21a.

Judge Owen concurred. She concluded the court did not need to resolve whether the Assignment Statute "relates to" an employee benefit plan because under the savings clause analysis this Court set forth in *Kentucky Association of Health Plans, Inc. v. Miller*, 538 U.S. 329 (2003), it was "saved from preemption under 29 U.S.C. § 1144(b)(2)(A) as a law that 'regulates insurance.'" Pet. App. 22a. Under that analysis, she would have held the statute was "specifically directed toward entities that engage in insurance," *id.* at 27a-28a, and that it substantially affected the risk pooling relationship by "alter[ing] the scope of permissible bargains between insurers and insured," *id.* at 29a. Judge Owen also rejected Blue Cross's complete preemption argument.

Blue Cross's petition for rehearing *en banc* was denied on September 15, 2006.

REASONS FOR DENYING THE WRIT

The Fifth Circuit's decision fully conforms to this Court's recent precedents, and the Petition identifies no persuasive justification for review by this Court.

1. The Fifth Circuit's decision is plainly correct. Where, as here, a statute squarely implicates an area of "traditional state power," the Fifth Circuit must presume that Congress did not intend to preempt the Louisiana Assignment Statute, absent evidence that it was "'the clear and manifest purpose of Congress'" to do so. *N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 655 (1995) (citation omitted). There is no such evidence here. As this Court's precedents demonstrate, Congress's decision to remain silent about the scope of assignment or alienation rights in fact suggests an intent *not* to preempt state statutes like this one. Moreover, the Assignment Statute directly serves ERISA's chief purposes, by facilitating the provision of care and benefits to beneficiaries and eliminating Blue Cross's ability to impose unnecessary transaction costs on the entire health care and health insurance system.

The Fifth Circuit's holding is also consistent with all of this Court's modern ERISA preemption jurisprudence. The Petition invokes *Egelhoff*, but there this Court held only that ERISA preempted a state law that *took away* a plan participant's right to designate a beneficiary for pension benefits, and required plan administrators to instead look to a web of state statutes to determine beneficiary status. By requiring insurers to *honor* the beneficiary's assignment of benefits to the participant's health care provider, the statute is consistent with ERISA's goals.

The Fifth Circuit's ultimate conclusion on express preemption is also correct because, as Judge Owen explained, this statute is saved from preemption as a law regulating insurance. Consistent with *Miller*, the Assignment Statute is directed toward entities engaged in

insurance and substantially affects the risk pooling arrangement between the insurer and the insured.

Finally, the Fifth Circuit correctly rejected Petitioner's attempt to analogize this case to the "conflict" or "complete" preemption that this Court recognized in *Davila*. The Assignment Statute does not create any new cause of action to collect ERISA benefits. It simply requires insurers to honor valid state law assignments. Blue Cross's claim that ERISA nonetheless still requires it to pay its insureds directly, because that is what the Plan's language (that it drafted) says, is only true if the Assignment Statute is expressly preempted. This new argument adds nothing.

2. Nor does the Fifth Circuit's decision conflict with decisions of any other circuit. The petition claims a conflict with decisions from the Eighth and Tenth Circuits that were decided *before* this Court substantially altered and narrowed the scope of ERISA preemption beginning with its decision in *Travelers*. Both the Eighth and Tenth Circuits have since recognized that ERISA preemption decisions from the pre-*Travelers* era are no longer controlling or persuasive, and there is no reason to believe that those circuits would continue to follow the decisions creating the alleged split today.

Additionally, the Eighth and Tenth Circuit decisions involved generally applicable assignment principles. The laws in those cases would have permitted assignment of benefits to family members, creditors, and financial institutions and were not, under *Travelers*, clearly entitled to a presumption against preemption. In contrast, the Assignment Statute here only addresses the assignment of health benefits to hospitals that have already provided the underlying care and who are required to submit claims electronically on a National Uniform Bill providing a placeholder for verification. In light of these factual distinctions, there is no reason to conclude that the Eighth and Tenth Circuits would have decided this case any differently.

3. Finally, the Fifth Circuit's opinion is fully consistent with ERISA's objectives and logically follows from this Court's controlling precedents. Review is not warranted to resolve any recurring question or issue of practical import to the health care community.

The Petition identifies no conflict of authority or other issue meriting this Court's review. It should be denied.

I. THE FIFTH CIRCUIT'S DECISION DOES NOT CONFLICT WITH THIS COURT'S PRECEDENTS

The Fifth Circuit properly held that ERISA does not preempt the Assignment Statute. The Petition supplies this Court with no reason to conclude otherwise.

A. The Louisiana Assignment Statute Does Not "Relate To" ERISA Plans

As the Fifth Circuit correctly recognized, any ERISA preemption analysis must begin with this Court's decision in *Travelers*. In *Travelers*, this Court substantially narrowed ERISA's preemptive reach by rejecting the "uncritical literalism" in applying ERISA's "unhelpful text" that had defined prior ERISA preemption jurisprudence. This Court held that where the state law does not explicitly refer to ERISA plans, courts must look to ERISA's "objectives ... as a guide to the scope of the state law that Congress understood would survive," and must start with a presumption "that the historic police powers of the States were not to be superseded ... unless that was the clear and manifest purpose of Congress." 514 U.S. at 655 (quoting *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947)). This Court further observed that "nothing in the language of the Act or the context of its passage indicates that Congress chose to displace *general health care regulation which historically has been a matter of local concern.*" *Id.* at 661 (emphasis added).

Two years later, this Court rounded out the "*Travelers* trilogy." In *California Division of Labor Standards Enforcement v. Dillingham Construction*, 519 U.S. 316 (1997), this Court held that the presumption that ERISA

did not preempt state wage laws was not overcome where there was an "absence of positive indications on the part of Congress that apprenticeship or prevailing wage statutes would be superseded." 519 U.S. at 331 n.7. And in *De Buono v. NYSA-ILA Medical & Clinical Services Fund*, 520 U.S. 806, 814 n. 10 (1997), this Court reiterated that where a state law "targets only the health industry," "this point supports the application of the 'starting presumption' against pre-emption," and held that ERISA did not preempt a New York law which taxed a hospital owned by an ERISA-covered employee welfare benefit fund.

Applying *Travelers*, the Assignment Statute indisputably implicates areas of traditional state power. Not only is the statute located in the "public health and safety" title of the Louisiana code, but its chief purpose is to streamline the health insurance claims process. Under *Travelers*, the Assignment Statute is therefore entitled to a presumption against preemption. The only remaining question is whether "'it was the clear and manifest purpose of Congress'" to overcome that presumption. 514 U.S. at 655 (citation omitted). The Fifth Circuit correctly held that it was not.

First, as this Court already observed in *Mackey v. Lanier Collection Agency & Service, Inc.*, 486 U.S. 825, 836 (1988), Congress specifically chose to *allow* the assignment of welfare benefits when it enacted ERISA. Tellingly, although ERISA explicitly prohibits the assignment or alienation of pension benefits, *see* 29 U.S.C. § 1056(d)(1), Congress did not similarly bar the assignment of welfare benefits.[1] *Mackey*, 486 U.S. at 836. Thus, in *Mackey*,

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[1] Congress's decision to allow the assignment of welfare benefits but preclude the assignment of pension benefits makes eminent sense. The anti-assignment provision's purpose is "[t]o further ensure that the employee's accrued benefits are actually available for retirement purposes." H.R. Rep. No. 93-807, at 68 (1974), *reprinted in* 1974 U.S.C.C.A.N. 4670, 4734. As discussed *infra*, Congress intended that welfare benefits be paid out to cover immediate health care expenses—a goal that is furthered, not obstructed, by the Assignment Statute.

because Congress's silence "concerning the assignment or garnishment of ERISA welfare plan benefits" reflected a decision to "'acknowledge[] and accept[] the practice, rather than prohibiting it,'" the Court held that ERISA did not preempt a state law allowing garnishment of an employee welfare benefit plan. 486 U.S. at 837-38 (citation omitted). Surely if Congress allowed a collection agency to use state law to garnish an employee welfare benefit plan, it failed to voice a "clear and manifest" intent to preempt a state law allowing a health care provider (designated as a plan participant's assignee) to recover plan benefits.

ERISA's definition of "beneficiary" confirms that conclusion. Congress defined a "beneficiary" as "*a person designated by a participant*, or by the terms of an employee benefit plan, who is or may become entitled to a benefit thereunder." 29 U.S.C. § 1002(8) (emphasis added). Petitioner's claim that Congress manifestly intended to preempt state laws allowing an assignment cannot be squared with Congress's obvious intent to create a class of beneficiaries through assignment. Consistent with *Mackey* and the definition of "beneficiary," several courts of appeals have interpreted ERISA's text as allowing assignments[2]—further proof that Congress did not express any clear and manifest intent to preempt statutes like this one.

Second, the Assignment Statute plainly comports with ERISA's objectives. Congress enacted ERISA "to promote the interests of employees and their beneficiaries in employee benefit plans." *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 90 (1983); *see also* 29 U.S.C. § 1001(b) ("It is hereby declared to be the policy of this Act to protect ... the interests of participants in employee benefit plans and their beneficiaries ...."). The Assignment Statute furthers

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2 *See, e.g., City of Hope Nat'l Med. Ctr. v. Healthplus, Inc.*, 156 F.3d 223, 226 (1st Cir. 1998); *St. Francis Reg'l Med. Ctr. v. Blue Cross & Blue Shield of Kan., Inc.*, 49 F.3d 1460, 1464 (10th Cir. 1995); *Davidowitz v. Delta Dental Plan of Cal., Inc.*, 946 F.2d 1476, 1478 (9th Cir. 1991); *Hermann Hosp. v. MEBA Med. & Benefits Plan*, 845 F.2d 1286, 1289 (5th Cir. 1988).

ERSA's purposes because it "facilitates rather than hampers the employee's receipt of health benefits," *Hermann Hosp. v. MEBA Med. & Benefits Plan*, 845 F.2d 1286, 1289 & n.13 (5th Cir. 1988), by enabling patients to promptly recoup their benefits without having to seek reimbursement following an out-of-pocket payment. Patients who cannot pay in advance are particularly benefited. Without assignment, those patients would likely not seek the requisite health care (thereby putting off necessary treatment until a costly emergency), and providers might avoid serving those patients because of the risk of nonpayment.

Honoring assignments also increases efficiencies. The Louisiana Assignment Statute increases the likelihood that patients receive their benefits and that hospitals are compensated. Moreover, it allows hospital claims specialists to deal directly with insurers and more efficiently navigate the complicated maze of claim forms and procedures required to obtain relief. As Petitioner conceded at the district court, the consolidated electronic filing process used by hospitals is more efficient and is beneficial to *both insurers and providers*. R. 2:211-28. Under Louisiana law, hospitals provide proof of loss on the UB-92 claim form or HCFA Form 1500 (or its successor), La. Rev. Stat. Ann. § 22:214.3(A) (2007)—forms that are both promulgated by the Centers for Medicaid and Medicare Services and include a space for a beneficiary to assign his benefits. R. 2:327-328 (Ex. 3). The Assignment Statute thus simply requires that ERISA plan administrators acknowledge an assignment designated on a routine federal government claim form they must process daily anyway. Pet. App. 17a-18a. Indeed, Blue Cross conceded that "it must honor assignments made under non-ERISA plans, which suggests that it already has in place some administrative mechanism for complying with the statute." *Id.* at 18a. Allowing beneficiaries to assign their benefits to a provider does not upset the plan's administration or impose additional costs on the insurer.

In contrast, an insurer's refusal to honor assignments burdens the entire health care and health insurance systems with the deadweight transaction costs associated with indirect reimbursements, and the attendant unnecessary litigation, thereby increasing costs and premiums and/or decreasing benefits for everyone. When assignments are not honored and a plan does not properly pay benefits, the healthcare provider either must rely on the beneficiary to bring an ERISA suit and then intervene in the action pursuant to Rule 24, or, worse, sue the beneficiary. Moreover, under *Mackey*, a hospital that provided services to a plan participant and is not paid can sue the participant directly, obtain a judgment, and then garnish the benefit plan to recover payment. Honoring assignments avoids such unnecessary effort, expense, and turmoil while still paying the participant's medical bills.

Blue Cross's policy arguments boil down to its claim that the ability to bar assignment increases Blue Cross's leverage over those hospitals in "network" negotiations, which, Blue Cross claims, it uses (in part) to negotiate lower prices. Of course the same would be true of any state law giving Blue Cross control over something that hospitals need, and here the countervailing cost is a serious blow to the efficiency of claims administration and to the prompt payment of benefits to beneficiaries, including beneficiaries of ERISA covered plans. In this area of traditional state regulation, Louisiana is entitled to conclude that whatever social benefit might be produced by giving Blue Cross yet another club to wield in negotiations is not worth the social costs. Nothing in ERISA demonstrates any clearly manifested contrary intent on the part of Congress.

Blue Cross invokes this Court's decision in *Egelhoff*, but that case is fully consistent with the Fifth Circuit's reasoning here. In *Egelhoff*, this Court held that ERISA preempted a Washington statute that, by operation of law, revoked the designation of a spouse as the beneficiary of all non-probate assets—including ERISA plan benefits—after the marriage ended. *See* Wash. Rev. Code § 11.07.010(2)(a)

(1994). This Court concluded ERISA preempted the Washington statute because the statute forced ERISA plan administrators to pay benefits to persons "chosen by state law," 532 U.S. at 147, rather than to the beneficiary's own designee, and because it burdened plan administration by forcing administrators to look outside the plan documents and the beneficiary's own elections to determine beneficiary status. *Id.* at 148-49 (noting that, under the Washington statute, plan administrators "must familiarize themselves with state statutes so that they can determine whether the named beneficiary's status has been 'revoked' by operation of law").

The Petition argues that the Fifth Circuit "failed to follow [*Egelhoff*'s] overriding instruction to evaluate the validity of a state statute by considering its impact on the ERISA objectives of ensuring that plan administration, and benefit payment, occur in accordance with valid plan provisions." Pet. 16. That is incorrect. The Fifth Circuit rightly concluded that the chief concerns animating this Court's decision in *Egelhoff* are not present here.

First, the court correctly observed that unlike the statute in *Egelhoff*, the Louisiana Assignment Statute does not designate by law a beneficiary that is outside of the two classes of "beneficiaries" ERISA permits, *see* 29 U.S.C. § 1002(8) (defining beneficiary as a plan participant or person "designated by a participant"), let alone a beneficiary that nullifies the plan participant's preference. Far from supplanting the free will of the ERISA plan participant, the Louisiana statute protects it. Pet. App. 15a. Petitioner claims that the Fifth Circuit's interpretation "gives short shrift to the express statutory terms" because administrators are obligated to pay beneficiaries who are "'designated by a participant ... *who is or may become entitled to a benefit thereunder*,'" Pet. 15 (quoting 29 U.S.C. § 1002(8) (emphasis in Petition). That is an overly technical reading—particularly in light of *Travelers* admonition against "uncritical literalism" in ERISA's application.

Second, the Fifth Circuit correctly concluded the statute's "burden on plan administrators is minimal." Pet. App. 17a. Rather than forcing ERISA plan administrators to look to a morass of state statutes to determine potential beneficiaries, *see Egelhoff*, 532 U.S. at 148-49, the court found the Louisiana Statute, by using the National Uniform Bill, creates no additional paperwork for plan administrators who do not pay benefits until they receive that claim form. Pet. App. 17a-18a. Petitioner thus brought substantial administrative burdens *on itself* in a convoluted effort to avoid complying with this eminently sensible law.

B. The Louisiana Assignment Statute Is Saved From Preemption As A Law Regulating Insurance

The Fifth Circuit's judgment also does not conflict with *Egelhoff* because the statute falls within ERISA's savings clause. 29 U.S.C. § 1144(b)(2)(A) (2006) (providing that "nothing in this title shall be construed to exempt or relieve any person from any law of any State which regulates insurance"). As Judge Owen's concurrence explains, the Louisiana Statute is "saved from preemption ... as a law that 'regulates insurance.'" Pet. App. 22a.

In *Kentucky Association of Health Plans, Inc. v. Miller*, 538 U.S. 329, 341-42 (2003), this Court held that to be saved from preemption (1) "the state law must be specifically directed toward entities engaged in insurance" and (2) "the state law must substantially affect the risk pooling arrangement between the insurer and the insured." This Court applied those factors in *Miller* to hold that Kentucky's "Any Willing Provider" ("AWP") statute—which required health insurers to accept in their plan any provider willing to meet the terms for participation established by the insurer—was saved from preemption. *Id.* at 331-32. First, this Court rejected the insurers' claim that the AWP statute was not "specifically directed toward" insurers because the law had the effect of preventing providers from creating their own preferred provider networks with insurers. The law's effect on the conduct of parties outside the insurance

industry did not diminish the fact that it was directed at insurers. *Id.* at 334-36. This Court also rejected the insurers' claim that the AWP law failed to control the actual terms of an insurance policy, but instead regulated "the relationship between an insurer and third-party provider." *Id.* at 337. Second, this Court concluded that while the statute did not alter the terms of insurance policies, it did substantially affect the risk pooling arrangement because it "expand[ed] the number of providers from whom an insured may receive health services" and "alter[ed] the scope of permissible bargains between insurers and insureds." *Id.* at 338-39.

As Judge Owen correctly reasoned, the Assignment Statute qualifies as a law regulating insurance under *Miller*. First, the Statute is indisputably "directed toward entities that engage in insurance." As the text suggests, the Louisiana legislature's purpose was to streamline the insurance claims process and to require any entity serving in an *insurance capacity* to recognize a beneficiary's assignment of insurance benefits.[3] La. Rev. Stat. Ann. § 40:2010 ("No *insurance* company, employee benefit trust, self-insurance plan, *or other entity which is obligated to reimburse the individual* ....") (emphasis added); *cf. Wash. State Dep't of Social & Health Servs. v. Guardianship Estate of Keffeler*, 537 U.S. 371, 384 (2003) ("'[W]here general words follow specific words ... the general words are construed to embrace only objects similar in nature to those objects enumerated by the preceding specific

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[3] The petition asserts that "[t]he panel's decision ... is so broadly worded that, arguably, it impacts all ERISA plans, includ[ing] self-funded as well as insured plans." Pet. 26. The Louisiana Commissioner of Insurance stated, however, that "the Department does not enforce the Louisiana assignment statute against ERISA plans or their administrators. It enforces the statute only against insurers acting as insurers." R. 9:1553 (Ex. B, Declaration of J. Robert Wooley, ¶¶ 4-5). The Fifth Circuit thus stated that "[t]his case asks us to decide whether [ERISA] preempts the assignment statute to the extent that it applies to fully insured ERISA plans." Pet. App. 1a-2a.

words.'").[4] Indeed, Petitioner brought this action in response to an investigation by the *Louisiana Department of Insurance* conducted pursuant to the insurance code, La. Rev. Stat. Ann. § 22:1214(12). Petitioner cannot credibly argue that the Assignment Statute does not regulate insurers "'with respect to their insurance practices.'" *Miller*, 538 U.S. at 334 (quoting *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 366 (2002)).

Second, the Louisiana statute "substantially affects the risk pooling arrangement between the insurer and the insured in much the same way as the state law at issue in [*Miller*]," Pet. App. 29a (Owen, J., concurring), by "alter[ing] the scope of permissible bargains between insurer and insured." 538 U.S. at 338-39. The Assignment Statute alters the behavior of insureds in ways that both decrease and increase the insurers' losses, thereby affecting the premiums the insurer can charge. For example, the statute prevents the addition of a new layer of risk by reducing the hazard resulting from the payment of benefits directly to insureds, who might fail to pay the hospital that actually provided the services.[5] Such insureds would have an incentive to over-utilize medical services, increasing the

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[4] The statute's placement in the "Public Health and Safety" title does not diminish that fact. *See, e.g., Standard Sec. Life Ins. Co. of N.Y. v. West*, 267 F.3d 821 (8th Cir. 2001) (holding that statute outside the insurance code nevertheless fell within the scope of the savings clause); *Mut. Reinsurance Bureau. v. Great Plains Mut. Ins. Co.*, 969 F.2d 931 (10th Cir.) (same), *cert. denied*, 506 U.S. 1001 (1992). To hold that it does require a finding of preemption would not only grossly oversimplify the ERISA preemption analysis contrary to the legislature's intent, *see* La. Rev. Stat. Ann. § 1:12 ("The classification and organization of the sections of the ... Statutes is made for the purpose of convenience, reference, and orderly arrangement, and no implication or presumption of a legislative construction shall be drawn therefrom."), but would ignore the fact that the Assignment statute is one part of an interlocking set of laws Louisiana has enacted to regulate the health insurance claims process.

[5] R. 9:1551 (Ex. C, Declaration of Sean McIntosh). This expert opinion is the only evidence in the record on this topic, and the Petitioner has made no effort to challenge its substantive conclusions.

risk for which the insurer and insured are contracting. On the other hand, Blue Cross argues that the Assignment Statute limits the permissible bargains between the insurer and insured in a way that actually *increases* the risk for which they are contracting, by limiting Blue Cross's ability to negotiate down the price of medical services.

Indeed, the parallels with *Miller* are particularly strong because the Assignment Statute increases the number of hospitals to which plan participants have effective access. Just as the AWP statute affected risk pooling because Kentucky insureds could no longer "seek insurance from a closed network of health-care providers in exchange for a lower premium," *Miller*, 538 U.S. at 338-39, the Louisiana statute prevents insurers from limiting assignments to a closed network of health-care providers in exchange for lower premiums. By expanding the pool of hospitals willing to treat Petitioner's insureds, the Louisiana statute, like the AWP statute in *Miller*, directly affects the type of risk pooling arrangements insurers may offer.

The statute's overriding emphasis on insurance also explains why this case is entirely different from—and not controlled by—*Egelhoff*. Although Petitioner protests that, by requiring an insurer to recognize an assignment, the statute compels it to violate the terms of its ERISA plan, Pet. 15, this Court has already expressly rejected that argument in *UNUM Life Ins. Co. of Am. v. Ward*, 526 U.S. 358, 375 (1999), *overruled on other grounds by Kentucky Association of Health Plans, Inc. v. Miller*, 538 U.S. 329 (2003), where it held that the "'contra plan term' argument overlooks controlling precedent and makes scant sense." This Court noted that, under Petitioner's argument, "States would be powerless to alter the terms of the insurance relationship in ERISA plans; insurers could displace any state regulation simply by inserting a contrary term in plan documents." *Id.* at 376. That "interpretation would virtually 'read the saving clause out of ERISA.'" *Id.* (citation omitted).

In sum, the Assignment Statute's obvious regulation of insurance compels the conclusion that it would be saved from preemption even if it did "relate to" ERISA plans within the meaning of the express preemption clause.

C. The Fifth Circuit's Decision Does Not Conflict With This Court's Application Of Conflict Preemption Principles In *Davila*

Apart from its express preemption arguments, the Petition also contends that the Fifth Circuit's opinion "conflicts with Supreme Court authority requiring preemption of state laws that conflict with ERISA's exclusive enforcement mechanism"—specifically, this Court's decision in *Aetna Health Inc. v. Davila*, 542 U.S. 200 (2004). Pet. 20. Petitioner argues that the Assignment Statute conflicts with ERISA's civil enforcement scheme because it somehow creates a new cause of action and allows for double recovery against an ERISA plan. This argument, which the Fifth Circuit unanimously rejected, is a purposeless sideshow.

In *Davila*, the Texas Health Care Liability Act ("THCLA"), Tex. Civ. Prac. & Rem. Code Ann. §§ 88.001-88.003, authorized the plaintiffs to bring a medical malpractice claim against their HMOs based on injuries they allegedly suffered due to the HMO administrators' decision not to provide coverage for treatment recommended by the plaintiffs' physicians. Relying on ERISA's plain text, this Court held that the plaintiffs' attempt to subject their HMO to liability for coverage decisions duplicated the cause of action under ERISA § 502(a)(1)(b) which allows a plan participant to recover wrongfully denied benefits. This Court reaffirmed that, under the complete preemption doctrine, "any state-law cause of action that duplicates, supplements, or supplants the ERISA civil enforcement remedy conflicts with the clear congressional intent to make the ERISA remedy exclusive and is therefore pre-empted." 542 U.S. at 209.

Petitioner cannot shoehorn this case into the *Davila* framework because the Assignment Statute does not create

any new cause of action. As the Fifth Circuit correctly observed, on its face "the assignment statute does not create an additional means to enforce payment of benefits under an ERISA plan." Pet. App. 10a. It simply regulates the assignment of the federal cause of action created by § 502 of ERISA. And the Petition identifies no evidence that Louisiana courts have recognized any implied private right of action to enforce the Assignment Statute, or that the state legislature ever contemplated such a right of action.

Petitioner argues that the Assignment Statute violates *Davila* because it "contemplates a double payment of the same benefit." Pet. 23. It claims that under ERISA it *must* pay the beneficiary regardless of whether, consistent with the Assignment Statute, the beneficiary has assigned his or her benefits to the hospital. *Id.* But that circular argument simply assumes that ERISA preempts the Assignment Statute. If the Assignment Statute is not preempted and there is a valid assignment, then the insurer is not obligated to pay the beneficiary rather than the assignee. Thus, "[i]f Blue Cross complies with the assignment, then it only pays one time; if Blue Cross ignores the assignment, then it risks paying a claim twice." Pet. App. 11a. Moreover, Petitioner's own policy language requires it to respect assignments "as required by law." R. 2:306. Blue Cross faces a conflict between its obligations under the Assignment Statute and its obligations under its policy language only if the Assignment Statute is expressly preempted—in which case this complete preemption argument adds nothing.[6]

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[6] The Petition's related claim that the Assignment Statute "enlarges the claim" available under ERISA "because it requires Blue Cross to pay money to the hospital even if it has already paid benefits to the participant" is similarly without merit. Pet. 24. As the Fifth Circuit unanimously observed, the Assignment Statue does not enlarge the rights or remedies of beneficiaries because "[t]he assignee takes what the assignor had; no more, no less." Pet. App. 10a; *see also id.* at 32a (Owen, J., concurring) (noting the statute "simply directs to whom payment must be made once there has been a valid assignment").

II. THE PETITION IDENTIFIES NO CONFLICT IN THE LOWER COURTS THAT IS APPROPRIATE FOR REVIEW

The Petition argues that the Fifth Circuit's decision conflicts with the Eighth Circuit's decision in *Arkansas Blue Cross & Blue Shield v. St. Mary's Hosp., Inc.*, 947 F.2d 1341 (8th Cir. 1991), *cert. denied*, 504 U.S. 957 (1992), and the Tenth Circuit's decision in *St. Francis Regional Medical Center v. Blue Cross & Blue Shield of Kansas, Inc.*, 49 F.3d 1460 (10th Cir. 1995), both of which held that ERISA expressly preempted assignment statutes of general applicability. Pet. 17. The claimed split is ephemeral. The Eighth and Tenth Circuit decisions, decided 16 and 12 years ago respectively, rested entirely on jurisprudence this Court explicitly disavowed in *Travelers*. Since *Travelers*, only the Fifth Circuit has considered whether ERISA expressly preempts a state assignment statute (general or specific). It is therefore premature to review the issue. Moreover, because the Eighth and Tenth Circuit cases involved generally applicable assignment statutes that were not specifically directed at the assignment of health insurance policies to hospitals, those cases are also distinguishable on their facts and do not facially implicate the savings clause. In short, there is no reasonable basis to conclude that either the Eighth or the Tenth Circuits would decide *this* case, *today*, any differently from the Fifth Circuit.

A. Review of The Alleged Conflict Is Premature Because The Lower Courts Have Not Considered The Application Of Intervening Supreme Court Precedent

1. In *St. Mary's*, the Eighth Circuit held that ERISA preempted Arkansas's "generally applicable" assignment statute where an insured assigned its rights under the ERISA plan to a health care provider. The Eighth Circuit's analysis was based on a multi-factor test that it extrapolated from several other courts of appeals decisions. 947 F.2d at 1344-45 (relying on factors from Second, Fifth, Sixth, and

Ninth Circuits decisions). Its analysis of many of those factors is plainly untenable after *Travelers*.

First, the Eighth Circuit started from the assumption that this Court "broadly interpret[s]" ERISA's express preemption clause, 947 F.2d at 1344, and it *explicitly disclaimed* any consideration of traditional state powers as a factor, concluding that it was, at best, "arguably ... a policy consideration useful in deciding borderline questions of ERISA preemption." *Id.* at 1350 ("[W]e are 'not convinced that ... the traditional or nontraditional nature of the state law ... properly bears upon'" the express preemption question. (citation omitted) (omissions in original)). *Travelers*, of course, squarely rejected both assumptions and implemented a clear presumption *against preemption* that applies in cases involving regulation of "traditional state powers." 514 U.S. at 655.

Second, the Eighth Circuit examined ERISA's text and legislative history and reasoned that preemption was appropriate in light of Congress's silence on the assignment of welfare benefits. *St. Mary's*, 947 F.2d at 1349 (reasoning that if Congress had wanted to preserve a role for state assignment law, it could easily have done so). That presumption in the preemption context is entirely wrong after *Travelers*—which requires courts to examine ERISA's text and legislative history for evidence that Congress intended to *overcome the presumption against preemption.* 514 U.S. at 655.

Third, the Eighth Circuit held that, because the Arkansas statute eliminated an incentive Blue Cross used to reward favored hospitals, it increased health care costs and caused "an economic impact on ERISA plans" warranting preemption. 947 F.2d at 1348-49. But the *Travelers* trilogy expressly rejected Petitioner's reasoning and held that an "economic effect" on an ERISA plan was insufficient to justify preemption where that economic effect merely "alters the incentives, but does not dictate the choices, facing ERISA plans," *Cal. Div. of Labor Standards Enforcement v. Dillingham*, 519 U.S. 316, 334 (1997).

The Eighth Circuit is not blind to these changes in the law. In *Wright Electric, Inc. v. Minnesota State Board of Electricity*, 322 F.3d 1025, 1029 (8th Cir. 2003), it not only acknowledged that "'*Travelers* plainly signaled a significant analytical shift in regard to ... the ERISA preemption inquiry, abandoning strict textualism in favor of more nuanced approach'" (citation omitted), but also declined to follow its prior decision in *Boise Cascade Corp. v. Peterson*, 939 F.2d 632 (8th Cir. 1991), *cert. denied*, 505 U.S. 1213 (1992)—decided just three months before *St. Mary's*—on the grounds that it was "no longer controlling in light of intervening Supreme Court cases, beginning with [*Travelers*]." The Eighth Circuit has not yet had the opportunity to reexamine *St. Mary's* holding in light of the *Travelers* trilogy, but there is no reason to believe it would adhere to that decision today.

2. The same holds true for the Tenth Circuit's decision in *St. Francis*. Although the Tenth Circuit's ERISA preemption analysis is less thorough than the Eighth Circuit's analysis in *St. Mary's*, it is no less antiquated. Like the Eighth Circuit, the Tenth Circuit "construe[d] ERISA's preemptive scope broadly," did not apply a presumption against preemption, did not consider the argument that the court should defer to the states' traditional powers in the area of health care, and interpreted congressional silence as favoring preemption. 49 F.3d at 1464. And the Tenth Circuit has also acknowledged that pre-*Travelers* jurisprudence relied on assumptions that are no longer tenable. In *Willmar Electric Service, Inc. v. Cooke*, 212 F.3d 533, 537 (10th Cir.), *cert. denied*, 531 U.S. 979 (2000), the Tenth Circuit refused to rely on pre-*Travelers* jurisprudence (including the Eighth Circuit's opinion in *Boise Cascade*) in resolving an ERISA express preemption question, noting that "these cases are not persuasive because they preceded the Supreme Court's delineation of the limits of ERISA preemption in cases such as *Travelers*, *Boggs*, *Dillingham*, and *DeBuono*." There is every reason

to conclude that the Tenth Circuit would not regard *St. Francis* as good law today.

The alleged "split" is therefore illusory and obsolete. If the Circuits genuinely view these issues differently in the wake of the *Travelers* trilogy, there will be plenty of opportunities for them to articulate their positions. Twenty-one states have statutory assignment provisions.[7] These states are located in nine different circuits,[8] including the Eighth and Tenth Circuits, which could reconsider the issue in light of this Court's recent precedent. This Court will have ample opportunity to review the issue if a true conflict emerges.

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[7] The following states have statutes requiring an insurer to pay benefits directly to a provider of healthcare services in certain situations: Alabama (Ala. Code § 27-1-19(a)–(b)); Alaska (Alaska Stat. § 21.54.020(a), Alaska Stat. § 21.51.120(a), Alaska Stat. § 21.54.050(a)); Arkansas (Ark. Code Ann. § 4-58-102); California (Cal. Ins. Code § 10133, Cal. Ins. Code § 10133.7(a)); Colorado (Colo. Rev. Stat. § 10-16-106.7(1)(a), Colo. Rev. Stat. § 10-16-317.5); Connecticut (Conn. Gen. Stat. § 38a-491b, Conn. Gen. Stat. § 38a-517b)); Florida (Fla. Stat. Ann. § 627.638(2)); Georgia (Ga. Code Ann. § 33-24-54(a), Ga. Code Ann. § 33-24-59.3(b)); Louisiana (La. Rev. Stat. Ann. § 40:2010); Maine (Me. Rev. Stat. Ann. tit. 24, § 2332-H, Me. Rev. Stat. Ann. tit. 24-A, § 2755, Me. Rev. Stat. Ann. tit. 24-A, § 2827-A, Me. Rev. Stat. Ann. tit. 24-A, § 4207-A(5-A)); Nevada (Nev. Rev. Stat. Ann. § 689A.135); New Hampshire (N.H. Rev. Stat. Ann. § 420-B:8-n(VIII)); Ohio (Ohio Rev. Code Ann. § 3901.386); Oklahoma (Okla. Stat. tit. 36, § 6055(D)–(E)); Rhode Island (R.I. Gen. Laws § 27-18-63), R.I. Gen. Laws § 27-19-54, R.I. Gen. Laws § 27-20-49, R.I. Gen. Laws § 27-20.1-18, R.I. Gen. Laws § 27-41-66); South Dakota (S.D. Codified Laws § 58-17-61); Tennessee (Tenn. Code Ann. § 56-7-120); Texas (Tex. Ins. Code Ann. § 1204.053, Tex. Ins. Code Ann. § 1204.054, Tex. Ins. Code Ann. § 1251.005); Virginia (Va. Code Ann. § 38.2-3407.13, Va. Code Ann. § 38.2-4215); Washington (Wash. Rev. Code § 48.44.026); Wyoming (Wyo. Stat. Ann. § 26-15-136(b)).

[8] The following circuits have states with assignment statutes: First (Maine, New Hampshire, Rhode Island), Second (Connecticut), Fourth (Virginia), Fifth (Louisiana, Texas), Sixth (Ohio, Tennessee), Eighth (Arkansas, South Dakota), Ninth (Alaska, California, Nevada, Washington), Tenth (Colorado, Oklahoma, Wyoming), and Eleventh (Alabama, Florida, Georgia).

B. The Alleged Conflicts Are Illusory Because The Eighth And Tenth Circuits Have Analyzed ERISA Preemption In The Context Of Vastly Different State Statutes

Additionally, substantial factual differences between the generally applicable assignment principles at issue in the pre-*Travelers* Eighth and Tenth Circuit decisions and the far narrower Louisiana Assignment Statute cast considerable doubt on the alleged split.

1. The Arkansas assignment statute the Eighth Circuit considered in *St. Mary's* bore virtually no similarity to the Louisiana Assignment Statute. That statute provided that "'[a]ll bonds, bills, notes, agreements, and contracts in writing, for the payment of money or property, or for both money and property, *shall* be assignable.'" 947 F.2d at 1343 (quoting Ark. Code Ann. § 4-58-102 (1987)). The Eighth Circuit held that ERISA preempted that statute where a beneficiary sought to assign its rights to a health care provider. For at least three reasons the Petitioner ignores, that holding does not establish a conflict with the Fifth Circuit's decision below.

First, the statutes have substantially different effects on ERISA plan administration. The Arkansas statute allowed beneficiaries to "pay a provider with personal funds and assign their welfare benefits to third parties" such as family members, creditors, or financial institutions. 947 F.2d at 1347. The Eighth Circuit reasoned that "[s]uch assignments would create numerous administrative hassles because there is no mechanism for providing the insurer with notice of these assignments and, potentially, the administrator would have to cope with conflicting assignments." *Id.* The Louisiana Assignment Statute does not suffer from any of those dangers because it only requires administrators to respect assignments of health insurance benefits to the hospital that actually provided the care, on a standard form that eliminates any risk of double assignment.

Similarly, the Eighth Circuit summarily found in *St. Mary's* that requiring the insurer to recognize assignments

complicated ERISA plan administration because it required insurers to change their practices and look to the National Uniform Bill (there, a UB-82 form) in processing claims. *Id.* at 1347. Under Louisiana law, however, Petitioner *already* must use the standard government form. The Fifth Circuit thus observed that the "assignment statute will not create any additional paperwork for Blue Cross and, in fact, *it may lessen Blue Cross's administrative responsibilities.*" Pet. App. 17a-18a (emphasis added) (stating "the burden on plan administrators is minimal"). Indeed, the court noted, "[t]he burden seems greater when many individuals [sic] plan participants must each individually file claims with Blue Cross ...." *Id.* at 18a.

Second, there are substantial *legal* distinctions between a statute which allows anyone to assign virtually anything to anyone else and a statute that requires an insurer to recognize a insured's assignment of health insurance benefits to the health care provider that provided the care. The Arkansas Assignment Statute did "not directly regulate health care costs" specifically, and did not regulate an area of traditional state authority. 947 F.2d at 1350-51. The Eighth Circuit could not have made the same finding with regard to the Louisiana statute, which is located in the "public, health, and safety" code and indisputably regulates an area of traditional state authority. The Eighth Circuit found regulation of traditional state authority important for "borderline cases," and reasoned that the absence of such regulation tipped the scales in *St. Mary's*. It clearly would have reached the opposite conclusion if faced with this statute, to say nothing of the conclusion it would have reached post-*Travelers*.

Third, there could not be any split on the ultimate issue of ERISA preemption because the Eighth Circuit did not reach the dispositive issue of whether the Arkansas statute was saved from preemption as a law regulating insurance. In other factual circumstances involving laws facially regulating insurance (and thus more analogous to the statute at issue here), the Eighth Circuit has applied the

savings clause to hold a statute is not preempted. *See, e.g., United of Omaha v. Bus. Men's Assurance Co. of Am.*, 104 F.3d 1034, 1041-42 (8th Cir. 1997). Thus, even if the Eighth and Fifth Circuit did disagree on the "relates to" question (which is far from clear), there is every reason to believe they would have reached the same conclusion here.

b. The Tenth Circuit's decision in *St. Francis* presents an even weaker candidate for a split. Contrary to the Petition's misleading assertion, the Tenth Circuit did not consider an "analogous state statute." Pet. 17. There was no statute. Instead, the Tenth Circuit considered whether ERISA preempted Kansas *public policy* (as articulated and developed through state common law decisions) favoring assignments. Kansas had enacted a law that expressly authorized Blue Cross Blue Shield of Kansas to refuse to honor assignments. Following Blue Cross's conversion from a non-profit to a mutual insurance company, St. Francis (a provider) sought a declaration that Blue Cross's continued refusal to honor assignments was against non-statutory Kansas public policy. *See St. Francis Reg'l Med. Ctr. v. Blue Cross Blue Shield of Kan., Inc.*, 810 F. Supp. 1209, 1211 (D. Kan. 1992) ("St. Francis contends that the non-assignment clause utilized by Blue Cross ... violates the Kansas public policy supporting free assignment of [cau]ses of action."). Blue Cross removed to federal court and claimed that ERISA preempted the common law public policy. The Tenth Circuit agreed.

Like the Arkansas law considered in *St. Mary's*, the Kansas public policy in *St. Francis* was a generally applicable principle favoring assignment of all obligations, to anyone. The Tenth Circuit's cursory reasoning is therefore distinguishable for all the reasons discussed above. Moreover, the amorphous nature of the Kansas public policy and the absence of any real record facts at the motion to dismiss stage may have made a more thorough analysis impossible. *St. Francis*, 49 F.3d at 1465 n.6 ("The district court ruled as a matter of law" on the preemption question "and hence did not rest its holding on any factual

considerations."). The court also did not evaluate the plan administration, the economic impact of the state law on ERISA plans, or whether the state law regulated an area of traditional state concern. Instead, the court's finding of preemption rested exclusively on its conclusion that because "ERISA itself is silent on the issue of assignability of benefits in insurance plans," Congress must have left "the assignability of benefits to the free negotiations and agreement of the contracting parties." *Id.* at 1464.

Applying pre-*Travelers* precedent and "construl[ing] ERISA's preemptive scope broadly," the Tenth Circuit gave no consideration to whether Congress left a question falling within a traditional area of state regulation *to the states* rather than to the contracting parties. *Id.* Because Kansas public policy did not purport to regulate insurance particularly, the Tenth Circuit had no occasion to consider whether the savings clause applied.[9]

III. THE PETITION DOES NOT RAISE ANY IMPORTANT QUESTION WARRANTING THIS COURT'S REVIEW

In the absence of a conflict, the Petition also claims that review is necessary "to provide guidance on matters of public policy and federal preemption." Pet. 25-26. No such guidance is necessary or appropriate at this time.

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[9] In one sentence, the Petition also argues the Fifth Circuit's decision conflicts with the First Circuit's decision in *City of Hope National Medical Center v. Healthplus, Inc.*, 156 F.3d 223 (1st Cir. 1998), the Eleventh Circuit's decision in *Physicians Multispecialty Group v. Health Care Plan of Horton Homes, Inc.*, 371 F.3d 1291 (11th Cir.), *cert. denied*, 543 U.S. 1002 (2004), as well as the Fifth Circuit's own decision in *LeTourneau Lifelike Orthotics & Prosthetics, Inc. v. Wal-Mart Stores, Inc.*, 298 F.3d 348 (5th Cir. 2002). Pet. 18-19. These decisions hold (unremarkably), that under ERISA parties are free to enter contracts restricting assignment. The courts had no reason to consider and did not address the significance of a state law regulating assignment, let alone whether such a law would be preempted and are therefore not in conflict with the decision below. And even if they were in conflict, the presence of an intra-circuit split is reason enough for this Court to deny review.

The Petition vastly overstates the Assignment Statute's effect on the health insurance industry. Petitioner claims that, despite its undeniable efficiencies, mandated honoring of assignments raises health care costs because it "eliminates" the leverage that insurers have to induce participation in their provider networks (and thereby to implement cost controls). Pet. 26. As Petitioner knows, insurers have many weapons in their arsenal to "induce" out-of-network providers, including the power to offer different (and less beneficial) reimbursement rates for out-of-network providers. Petitioner can use those methods to exert as much pressure on hospitals as its own power in the marketplace will allow.

By the same token, consumers and employers who know the differences in benefits can make an informed decision whether the purported savings from such methods are sufficient to offset the resulting loss of access to their preferred healthcare providers. Presumably that is why Blue Cross does not want to exert its market leverage in such an up-front manner. Blue Cross's own customers want to use their preferred hospitals, and might strongly consider alternatives if they routinely received bills for excess charges because Blue Cross refused to provide reasonable coverage at those preferred hospitals. Refusing to honor assignments, however, imposes painful costs, both monetary and intangible, on out-of-network hospitals and on plan participants and beneficiaries, and does so in a way that focuses the negative attention on the hospitals that are required to pursue the insured for payment, rather than on a defect in the insurance coverage. Blue Cross's desire to coerce providers into network so that it can lower reimbursement rates in a way that its insureds will not notice or understand serves no broader public interest. Blue Cross is free to discriminate aggressively in favor of its in-network providers, but it should do so forthrightly and in a manner that does not impose large, unnecessary deadweight transaction costs on the whole health care system.

Blue Cross also identifies no record evidence to support its claim that requiring it to recognize assignments will "discourage employers from establishing plans." Pet. 26. The absence of record evidence in its favor is not surprising. Petitioner does not seek to reverse a decision that unsettled the health care industry; rather it invites this Court to unsettle that industry by authorizing Blue Cross to deviate from the way it and the vast majority of insurers ordinarily do business. The assignment-of-benefits process has become the industry standard for private insurance companies—indeed, the record shows that Blue Cross itself was not equipped to handle the chaotic consequences of refusing to honor assignments, resulting in reimbursement delays and unpaid medical bills to providers. R. 9:1566. That is not surprising. Honoring assignments lowers the costs of ERISA plan administration and serves ERISA's purposes by streamlining the reimbursement process and guaranteeing that insurance funds make their way to the provider. Pet. App. 48a. That, in turn, lowers costs and premiums, improves access to health care, encourages participants to regularly seek health care, and particularly helps the increasingly large segment of the population that cannot afford to pay in advance for their treatment.

Finally, the decision below does not demonstrate that ERISA preemption jurisprudence is ambiguous or uncertain. *Travelers* and its progeny provide a straightforward framework for analyzing whether ERISA preempts a statute regulating health benefit plans, which the Fifth Circuit correctly applied to conclude that ERISA does not preempt the Assignment Statute.

CONCLUSION

For the reasons set forth above, the Petition for certiorari should be denied.

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No. 06-839

IN THE

Supreme Court of the United States

LOUISIANA HEALTH SERVICE & INDEMNITY CO., doing business as Blue Cross and Blue Shield of Louisiana,
Petitioner,

v.

RAPIDES HEALTHCARE SYSTEM; STATE OF LOUISIANA; CHARLES R. FOTI, JR., Attorney General for the State of Louisiana; DAUTERIVE HOSPITAL,
Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

PETITIONER'S REPLY TO BRIEF IN OPPOSITION TO PETITION FOR A WRIT OF CERTIORARI

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INTRODUCTORY STATEMENT

The Fifth Circuit's decision that ERISA does not preempt the Assignment Statute creates a clear conflict with decisions of this Court and other circuits. The decision validates a state law that is contrary to lawful plan terms, conflicts with ERISA's exclusive civil enforcement mechanism, and interferes with the attainment of a national, uniform administrative scheme. Blue Cross asks this Court to review a decision that neglects fundamental ERISA tenets and contravenes Congressional intent.

ERISA expressly reserves control over the structure of ERISA plans to the plan sponsor, allowing it to designate, in the plan, *to whom* and how a plan administrator should pay ERISA plan benefits. ERISA obligates a plan administrator to act in accordance with such lawful plan terms, including terms that prohibit direct payment of benefits to anyone other than the plan participant or a network provider. And ERISA permits claims pursuant to those provisions to be enforced only under ERISA's exclusive civil enforcement scheme.[1] The Assignment Statute must be preempted by ERISA because it conflicts with those clearly expressed Congressional goals. Respondents' assertion that the Assignment Statute is consistent with the goals of ERISA because it facilitates participants' receipt of benefits underscores the fact that the statute indeed "relates to" ERISA plans.

Respondents detract attention from preemption principles by casting Blue Cross as a bullying insurance company, "brandishing a threat" (Opp. 1), "wielding a club" (Opp. 13), and "coercing providers" (Opp. 1), and asserting that provider or participant interests surpass all others.

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[1] ERISA Sections 402(b)(4), 404(a)(1)(D), 3(8), and 502(a)(1)(B), 29 U.S.C. §§ 1102(b)(4), 1104(a)(1)(D), 1002(8), and 1132(a)(1)(B), respectively.

Respondents' harsh tactics cannot overcome statutory language that demands a finding of preemption here. *See, e.g., Mertens v. Hewitt Associates,* 508 U.S. 248, 261 (1993) (vague notions of statute's purpose are inadequate to overcome words of its text regarding specific issue under consideration, especially regarding ERISA, "an enormously complex and detailed statute that resolved innumerable disputes between powerful competing interests – not all in favor of potential plaintiffs.").[2]

A. The Fifth Circuit decision conflicts directly with decisions of other circuits

The Fifth Circuit acknowledged expressly that its decision conflicts with analogous decisions by both the Eighth and Tenth Circuits.[3] Respondents argue that the Fifth Circuit erred in this assessment,[4] and resolution of the conflict would be premature, because the circuit split is "ephemeral" and "obsolete," and the conflicting decisions "antiquated." (Opp. 21-24.)

First, Respondents direct this Court to impose a new standard in determining whether a circuit split exists by asking how the lower courts "would decide *this* case,

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[2] Confounding logic, Respondents argue that ERISA preemption of the Assignment Statute would "inflict[] a deadweight loss on the entire health care system" (Opp. 1), while at the same time asserting that this case does not present any "issue of practical import to the health care community." (Opp. 9). Petitioners submit it is also disingenuous for Respondents to assert that this Court's prior decisions "provide a straightforward framework" for preemption analysis (Opp. 30), when Justices repeatedly bemoan the lack of clarity (Pet. 13 n.13).

[3] Pet. App. 18a.

[4] Consistent with their approval of and reliance upon only selected portions of the Fifth Circuit's opinion, Respondents also assert that plan language requires Blue Cross "to respect assignments 'as required by law,' " attempting to revive an argument that the Fifth Circuit explicitly rejected. Pet. App. 7a ("ERISA plans must always conform to state law, but only state law that is valid and not preempted by ERISA.")

today..."? (Opp. 21.) Respondents are incorrect. To be considered a conflict worthy of resolution, a circuit split need not be among contemporaneous decisions. *See, e.g., Empire HealthChoice Assur., Inc. v. McVeigh*, 126 S. Ct. 2121 (2006) (granting *certiorari* to resolve conflict among decisions issued between 1993 and 2005); *Geissal v. Moore Med. Corp.*, 524 U.S. 74 (1998) (granting *certiorari* to resolve conflict among decisions issued between 1989 and 1998); *Bulova Watch Co. v. United States*, 365 U.S. 753 (1961) (conflicting opinion rendered 22 years earlier); *Commissioner v. Stidger*, 386 U.S. 287, 289 (1967) (conflicting opinion rendered 18 years earlier).

Respondents next argue the Eighth and Tenth Circuits' decisions do not truly conflict with the Fifth Circuit's decision because the earlier opinions relied on an analysis rendered "plainly untenable" by *New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 658 (1995). (Opp. 22.) Respondents' tortured attempts to distinguish the lower court decisions are unavailing. This Court in *Travelers* reaffirmed the applicability of the factors relied upon in *Arkansas Blue Cross & Blue Shield v. St. Mary's Hosp., Inc.*, 947 F.2d 1341 (8th Cir. 1991), *cert. denied*, 504 U.S. 957 (1992), and *St. Francis Regional Medical Ctr. v. Blue Cross & Blue Shield*, 49 F.3d 1460 (10th Cir. 1995) (*see* Pet. 19-20), and the lower courts continue to rely on those factors in decisions issued after *Travelers*.

Respondents assert that "there is no reason to believe" the Eighth Circuit would adhere to its holding after *Travelers* (Opp. 23). Respondents are wrong. *See, e.g., Minn. Chptr. of Assoc. Builders & Contrs., Inc. v. Minn. Dep't of Pub. Safety*, 267 F.3d 807, 814-818 (8th Cir. 2001) (statute preempted because rather than merely encourage or provide economic incentives for compliance, the statute "absolutely demand[s] it," and has connection with ERISA based on the factors considered in *St. Mary's*, citing

Dillingham[5]), *cert. denied*, 535 U.S. 1096 (2002).[6]

Respondents next address the conflicting lower courts' failure to begin their analysis with a "presumption against preemption …in cases involving 'traditional state powers.'" (Opp. 22.) Whether or not the Assignment Statute addresses a historic police power, decisions after *Travelers* have overcome "the starting presumption that Congress does not intend to supplant state law,"[7] in cases where, as here, the state law affects ERISA plan administration. In *Egelhoff v. Egelhoff,* 532 U.S. 141 (2001) decided six years after *Travelers*, the Supreme Court held ERISA preempted a statute relating to family and probate law – concededly areas of traditional state regulation – because the presumption against preemption can be overcome when the state law conflicts with ERISA or relates to ERISA plans, citing *Boggs v. Boggs*, 520 U.S. 833 (1997) (ERISA preempts state community property law). 532 U.S. at 151. The state law at issue in *Egelhoff* functioned in the same manner as the

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[5] *California Div. of Labor Stds. Enforcement v. Dillingham Constr., N.A.*, 519 U.S. 316 (1997).

[6] *See also Prudential Ins. Co. of Am. v. Nat'l Park Med. Ctr., Inc.*, 413 F.3d 897, 908 (8th Cir. 2005) ("*Prudential II*") (approving the "significant" express preemption analysis it had conducted in *Prudential Ins. Co. of Am. v. Nat'l Park Med. Ctr., Inc.*, 154 F.3d 812 (8th Cir. 1998) ("*Prudential I*")). In *Prudential I*, the Eighth Circuit explicitly considered the impact of *Travelers*, 154 F.3d at 820-822, and stated, *inter alia*, "[W]e do not read *Travelers* to reject all of its prior precedent on the scope of ERISA preemption or as a wholesale rejection of the mode of analysis employed in the Court's prior precedent," 154 F.3d at 820. *Prudential I* concluded that the statute was expressly preempted as a law that makes impermissible "reference to" ERISA or ERISA plans. The court found it unnecessary to reach the question of whether the statue was also preempted under the "connection with" prong of the preemption analysis. *Id.*, at 825.

[7] *Travelers,* 514 U.S. at 655.

Assignment Statute: it dictated a benefit choice at odds with lawful plan language. *See also Dillingham,* 519 U.S. at 330 ("That the States traditionally regulated these areas would not alone immunize their efforts; ERISA certainly contemplated the pre-emption of substantial areas of traditional state regulation."); *Retail Industry Leaders Assoc. v. Fielder*, 475 F.3d 180, 183, 193 (4th Cir. 2007) (state statute preempted because it effectively requires employers to restructure employee health insurance plans, *i.e.*, "has an impermissible 'connection with' ERISA plan [because] it directly regulates or effectively mandates some element of the structure or administration of employers' ERISA plans"); *Bank of La. v. Aetna US Healthcare Inc.*, 468 F.3d 237, 242 (5th Cir. 2006) (ERISA preempts state law claim alleging improper processing and payment of benefit claims because it requires inquiry into area of exclusive federal concern); *Travelers,* 514 U.S. at 658 (state law preempted if it mandates employee benefit plan structure or its administration).

Next, Respondents argue that the economic impact of the Assignment Statute, to the extent it eliminates an incentive for providers to join the Blue Cross network, is no longer relevant to the preemption analysis. Respondents' citation of *Dillingham* and reliance on the *Travelers* trilogy to support this notion is incorrect. In *Dillingham,* this Court distinguished a statute that merely altered incentives to a plan, from a statute that "dictates the choices, facing ERISA plans." 519 U.S. at 334. With respect to the latter, *i.e.,* a statute that "is tantamount to a compulsion," preemption is the proper result; *id.* at 333. In contrast, a statute that "does not bind ERISA plans to anything," *id.* at 332, need not be preempted. The Assignment Statute purports to compel all ERISA plans to recognize assignments to all providers, thus binding the ERISA plan, and dictating its choices, with respect to plan administration. Under the reasoning of

Dillingham, the Assignment Statute is preempted because the state demands plan compliance with its requirements.[8]

B. The Assignment Statute relates to ERISA

ERISA Section 514(a), 29 U.S.C. § 1144(a), mandates preemption of the Assignment Statute because it requires plan administrators to pay benefits in a particular manner, in contravention of lawful plan terms, and thus relates to ERISA. (Pet. 13-16.)

Respondents argue that the Assignment Statute does not relate to ERISA because ERISA does not expressly bar assignments of welfare benefits. Citing *Mackey v. Lanier Collection Agency & Serv.*, 486 U.S. 825 (1988), Respondents assert Congressional silence evidences an intent to allow enforcement of assignment laws against ERISA plans. This argument is unpersuasive. In *Mackey*, this Court held ERISA did not preempt a *garnishment* statute that permitted the state to enforce a judgment *unrelated to the provision of ERISA benefits* against an ERISA plan. Neither the garnishment statute nor enforcement of a garnishment order would require the elimination of a lawful ERISA plan term.

In contrast, the Assignment Statute must be preempted because it purports to regulate a primary ERISA function – a plan's payment of plan benefits in accordance with ERISA plan terms – and purports to mandate the manner of payment in conflict with lawful plan provisions. Alienation of benefits by a third party via garnishment is distinguishable on this basis from participant assignments to providers, because an ERISA

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[8] The decisions relied upon by Respondents correctly recognize the distinction they overlook; *see Wright Elec., Inc. v. Minn. State Bd. of Elec.*, 322 F.3d 1025, 1031 (8th Cir. 2003) (noting correctness under *Dillingham* of ruling that ERISA preempts a state law that dictates the choices facing ERISA plans and mandates compliance with numerous requirements); *Willmar Elec. Serv. v. Cooke*, 212 F.3d 533, 537 (10th Cir. 2000) (discussing *Dillingham* analysis that statute's provision of economic incentive to comport with state's requirements does not bind ERISA plans to anything, and thus statute need not be preempted).

plan provision cannot govern creditor rights. *St. Mary's,* 947 F.2d at 1349; *see also Davidowitz v. Delta Dental Plan, Inc.*, 946 F.2d 1476, 1479 (9th Cir. 1991) (garnishment cases "cannot be stretched" to mean that "beneficiaries can freely assign notwithstanding a plan's non-assignment clause. They simply hold that state law may provide a statutory mechanism for judgment collection.").

Respondents misread *Egelhoff* as holding that ERISA preempts only state laws that "supplant[] the free will of the ERISA plan participant."[9] (Opp. 14). To the contrary, *Egelhoff* held a statute preempted because it contravened lawful plan terms that permitted a participant to designate a beneficiary,[10] not because it interfered with a participant's "free will." The Assignment Statute must be preempted because it supplants lawful plan terms regarding to whom benefit payments may be made. The plan sponsor's right to designate permissible beneficiaries, and the plan administrator's obligation to enforce such provisions, are acts regulated and protected by ERISA. To the extent a participant purports to designate a beneficiary that contravenes the plan terms, such designation is not enforceable.[11]

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[9] Characterization of the participant's assignment to the provider as an act of "free will" deserving of protection is questionable when one considers what really occurs in the context of a patient's admission to a hospital: a clerk presents a form for signature to the patient which, among other things, requires the participant to check a box that states he assigns his right to benefits to the hospital.

[10] 532 U.S. at 147.

[11] Respondents mischaracterize the ERISA definition of "beneficiary" and assert Petitioner's "reading" of the definition is "overly technical." Opp. 14. In fact, the statute's definition is plain and requires no "reading." A beneficiary is a person designated by a participant or by the plan terms, ERISA Section 3(8), but must be entitled to benefits under the plan terms. It is insufficient for a beneficiary to assert entitlement based on the participant's designation, if the plan terms prohibit payment

Finally, Respondents ask this Court to consider the effect of the savings clause,[12] an issue that was neither addressed nor resolved by the majority in its opinion. (Opp.15-19.) Respondents' focus on the savings clause cannot diminish the significance of the Fifth Circuit's decision that the Assignment Statute neither "relates to" ERISA, nor conflicts with ERISA's exclusive civil enforcement scheme. As a result of this ruling, the statute is applicable to and enforceable against all ERISA plans, included self-funded and insured plans.[13] (Pet. App. 21a.) However, the majority expressly did not consider whether the Statute nevertheless would be saved from preemption as a law regulating insurance. (Pet. App. 21a.) Thus, the savings clause analysis is irrelevant to the pending Petition and not properly a subject for review by this Court. *See, e.g., Lytle v. Household Mfg., Inc.*, 494 U.S. 545, 552 n.3 (1990) (it is not a sensible exercise of this Court's discretion to consider particular legal analysis without benefit of full record or lower court determination).[14]

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to that beneficiary. No beneficiary rights exist in the abstract; rather, the plan terms control beneficiary status. *See* Pet. 15 n. 18, citing *Cobb v. Cent. States*, 461 F.3d 632, 635 n.3 (5th Cir. 2006).

[12] ERISA Section 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A).

[13] The Fifth Circuit did not address the significance of the distinction between self-funded and insured plans for purposes of its ultimate preemption decision; *compare Prudential II,* 413 F.3d at 914 (statute saved from preemption except with regard to self-funded plans, but § 502 completely preempts statute's penalty provision with respect to any ERISA cause of action).

[14] If this Court grants the Petition, it may ultimately reverse and remand the Fifth Circuit's decision for further proceedings, at which time consideration of the savings clause issue would be appropriate. Petitioner then would demonstrate that the Assignment Statute is not saved from preemption under *Ky. Ass'n of Health Plans, Inc. v. Miller*, 538 U.S. 329 (2003), because (1) it is not specifically directed toward insurance entities; *see, e.g., Levine v. United Healthcare Corp.*, 402 F.3d 156, 166

C. The Assignment Statute conflicts with ERISA's exclusive civil enforcement scheme

ERISA's "extraordinary preemptive power" requires preemption of "any state-law cause of action that duplicates, supplements, or supplants the ERISA civil enforcement remedy," even if – as Respondents vehemently (albeit prematurely) urge – the state law would otherwise be saved from preemption as a law regulating insurance. *Aetna Health Inc. v. Davila*, 542 U.S. 200, 209, 217 (2004). Pet. 20-25. By expressly establishing a state cause of action "to collect benefits" and an extra-contractual remedy for providers, the Assignment Statute conflicts with ERISA's exclusive enforcement scheme.

Respondents assert that *Davila*, and Petitioner's analysis of same, "add[] nothing," (Opp. 8) and "[are] a purposeless sideshow" (Opp. 19). Yet the Assignment Statute's conflict with ERISA §502(a)(1)(B) is far from a sideshow. In ERISA §502(a)(1)(B), Congress provided the exclusive mechanism under which an action for ERISA plan benefits may be maintained, and the only available remedy

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(3d Cir. 2005) (statute not specifically directed toward insurance industry where it governed all civil actions, not merely those against insurers, and explicitly regulates both insurance and non-insurance entities; significant impact on insurance industry is not sufficient); and (2) it does not substantially affect the risk pooling arrangement between the insurer and the insured because it does not alter the bargain between the participant and the insurer, govern whether Blue Cross must cover a claim, or dictate to Blue Cross the conditions under which it must pay the claim; *see, e.g., Ellis v. Liberty Life Assur. Co.*, 394 F.3d 262, 277 (5th Cir. 2004) (remedial statute does not affect risk pooling because it does not affect initial bargain insurer makes with insured regarding coverage for disability); *cf., Singh v. Prudential Health Care Plan, Inc.*, 335 F.3d 278, 286 (4th Cir.) (statute that addresses *who pays* in given circumstances is directed at spreading risk), *cert. denied*, 540 U.S. 1073 (2003).

thereunder is the payment of benefits in the manner specified under the plan. The state is trying to rewrite ERISA by creating a cause of action under the Assignment Statute to "collect benefits," and by providing for an extra-contractual remedy, *i.e.,* a payment to a provider contrary to the plan terms.

ERISA's expansive preemption provisions are intended to ensure that regulation of ERISA plans and enforcement of their terms are "exclusively a federal concern." *Davila*, 542 U.S. at 208. The Assignment Statute conflicts directly with that intent, and therefore must be preempted. *See, e.g., Hutchison v. Fifth Third Bancorp*, 469 F.3d 583, 588 (6th Cir. 2006) (*Davila* requires preemption of state law claim relating to plan amendment that changed definition of beneficiaries because it "goes to the heart of what Congress intended ERISA to govern: the rights of beneficiaries under ERISA against plan administrators.... As long as ERISA exclusively regulates the activity..., ERISA prevents the distinct state law ... scheme from superimposing an extra layer of regulation on top of the ERISA-regulated plan benefit determination.")

CONCLUSION

For the foregoing reasons and for the reasons set forth in the Petition, the petition for a writ of certiorari should be granted.

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No. 06-839

IN THE

Supreme Court of the United States

LOUISIANA HEALTH SERVICE & INDEMNITY CO., D/B/A BLUE CROSS AND BLUE SHIELD OF LOUISIANA,
Petitioner,

v.

RAPIDES HEALTHCARE SYSTEM, ET AL.,
Respondents.

On Petition for Writ of Certiorari to the Court of Appeals for the Fifth Circuit

BRIEF FOR BLUE CROSS AND BLUE SHIELD OF ALABAMA, BLUE CROSS AND BLUE SHIELD OF KANSAS, INC., BLUE CROSS AND BLUE SHIELD OF NEBRASKA, BLUE CROSS AND BLUE SHIELD OF NORTH CAROLINA, BLUE CROSS AND BLUE SHIELD OF SOUTH CAROLINA, BLUECROSS BLUESHIELD OF DELAWARE, BLUE CROSS BLUE SHIELD OF FLORIDA, INC., BLUECROSS BLUESHIELD OF MICHIGAN, CAREFIRST OF MARYLAND, INC., EXCELLUS HEALTH PLAN, INC., GROUP HOSPITALIZATION AND MEDICAL SERVICES, INC., THE REGENCE GROUP, WELLMARK, INC., WELLPOINT, INC., AND AMERICA'S HEALTH INSURANCE PLANS, INC. AS AMICI CURIAE IN SUPPORT OF PETITIONER

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INTEREST OF THE AMICI CURIAE

Blue Cross and Blue Shield of Alabama, BlueCross BlueShield of Delaware, Blue Cross Blue Shield of Florida, Inc., Blue Cross and Blue Shield of Kansas, Inc., BlueCross BlueShield of Michigan, Blue Cross and Blue Shield of Nebraska, Blue Cross and Blue Shield of North Carolina, Blue Cross and Blue Shield of South Carolina, CareFirst of Maryland, Inc., Excellus BlueCross BlueShield, Group Hospitalization and Medical Services, Inc., The Regence Group, Wellmark, Inc., and WellPoint, Inc. are or operate independent, locally owned Blue Cross and Blue Shield Plans. Through insurance arrangements and administrative services agreements with employers, employee benefits plans, and individual subscribers, they furnish health benefits to tens of millions of Americans. In most instances, the provision of these benefits is governed by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001 *et seq*.

America's Health Insurance Plans, Inc. ("AHIP") is the national association representing the private health plan and insurer community. AHIP's mission is to advance health care quality and affordability through leadership in the health care community, advocacy, and the provision of services to its members. AHIP represents nearly 1,300 member companies that insure or administer health and other employee benefits to more than 200 million individuals, the majority of whom are covered through ERISA-governed plans.[1]

The Petition for a Writ of Certiorari presents questions concerning the states' power to regulate essential aspects of the administration of ERISA plans. The Fifth Circuit's

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[1] In accordance with Rule 37.6, the *amici* certify that counsel for a party did not author this brief in whole or in part and that no entity other than the *amici*, their members, or their counsel made a monetary contribution to the preparation or submission of the brief.

decision upholds -- against a preemption challenge -- a state law that requires ERISA plans to comply with an assignment of health benefits payments from plan participants to providers, even when ERISA plan provisions instruct differently. As such, the court of appeals' decision nullifies critical plan terms affecting claims payment. It also significantly undermines the ability of ERISA plans to create provider networks designed to contain plan costs and ensure quality care, since the promise of direct payment to a provider only upon joining a network is often the linchpin for a provider joining such a network. Given the decision's significant implications for ERISA plans, the *amici* -- as entities insuring and administering ERISA plans and the national association of health insurance plans -- have a strong interest in the Petition.

Counsel for the parties have consented to the filing of this *amicus* brief.

SUMMARY OF ARGUMENT

The Fifth Circuit's decision addresses an area now familiar to this Court and the lower courts: ERISA preemption. Specifically, the issue in the case is whether ERISA preempts Louisiana's law requiring health benefits plans, including ERISA plans, to accept assignments of rights to health benefits payments, when those assignments are from plan participants to hospitals. Because the Fifth Circuit's decision conflicts with the decisions of two other circuits, is counter to this Court's own precedents, and undermines the ability of ERISA plan sponsors, insurers, and administrators to create provider networks that are key to containing plan costs and ensuring quality care, the Court should grant the Petition.

1. The Fifth Circuit's decision created -- as it candidly noted -- a clear split among the circuits: the Eighth and Tenth Circuits had already addressed the same issue and found similar assignment laws preempted. The Fifth Circuit

attempted to play down the conflict by reasoning that the intervening decision in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*, 514 U.S. 645 (1995), somehow undercut the other circuits' determinations, but that analysis misreads *Travelers*. Indeed, contrary to the Fifth Circuit's reasoning, numerous courts well after *Travelers* have relied on and followed the Eighth and Tenth Circuits' holdings.

2. Not only is the Fifth Circuit's decision contrary to the rulings of other circuits, it conflicts with this Court's own precedents, in particular *Egelhoff v. Egelhoff*, 532 U.S. 141 (2001), and *UNUM Life Insurance Co. v. Ward*, 526 U.S. 358 (1999), by overriding plan terms and jeopardizing national uniformity in plan administration. The decision also is inconsistent with this Court's holdings that a state law supplementing or interfering with ERISA's comprehensive enforcement scheme is preempted under ordinary conflict preemption principles. The assignment statute does not simply transfer the available ERISA cause of action from one party to another; it creates an *additional* remedy, solely in the hands of the provider, to enforce the state statute's assignment terms.

The Fifth Circuit's preemption holding cannot be salvaged, as the concurrence below attempted, through application of ERISA's insurance saving clause. As an initial matter, the concurrence's saving clause analysis does not obviate the split in the circuits that warrants this Court's attention, because the majority's opinion applies to self-funded plans exempted from the saving clause. Hence, the conflict with the Eighth and Tenth Circuits remains. In any event, the Louisiana assignment statute does not, under the applicable saving clause test, constitute an insurance regulation, principally because it does not affect the risk pooling arrangement between an insurer and an insured. The statute has little to do with the substantive insurance bargain between the insurer and the insured, but instead regulates

provider rights. And even if the assignment statute were a law regulating insurance under the saving clause, the statute would still be preempted because it conflicts with ERISA's exclusive enforcement mechanism.

3. The Fifth Circuit's decision threatens a cost-containment tool central to ERISA plans and, in fact, to the Nation's entire health care delivery system -- namely, preferred provider networks. Today, rather than offering health maintenance organization ("HMO") plans exclusively, employers rely on hybrid models -- the most common of which are known as "preferred provider organizations" -- that encourage consumers to choose from a large network of providers who have agreed to discounted prices for their services. Such organizations are now the most prevalent form of health benefits arrangement in the United States.

The Fifth Circuit's decision, however, casts a pall over the creation of preferred provider networks. A chief incentive for a provider to join such a network is the promise of direct payment by the plan, payment that otherwise would be sent to the patient from whom the provider would then have to collect. By holding that state law may require direct payment to any provider with an assignment, the Fifth Circuit has seriously compromised plans' ability to establish preferred provider networks, to the detriment of plans and their participants. That threat to a principal structural component of ERISA health benefits plans warrants this Court's review.

ARGUMENT

I. THE FIFTH CIRCUIT'S DECISION CREATES A CIRCUIT SPLIT THAT COMPLICATES THE ADMINISTRATION OF NATIONWIDE PLANS

The Court should grant the Petition in order to resolve a split among the circuits. As the Fifth Circuit expressly acknowledged, its ruling that ERISA does not preempt state

assignment laws conflicts with existing precedent from the Eighth and Tenth Circuits. *See La. Health Serv. & Indem. Co. v. Rapides Healthcare Sys.*, 461 F.3d 529, 539-40 (5th Cir. 2006), *petition for cert. filed*, 75 U.S.L.W. 3333 (U.S. Dec. 14, 2006) (No. 06-839).

In *Arkansas Blue Cross & Blue Shield v. St. Mary's Hospital, Inc.*, 947 F.2d 1341 (8th Cir. 1991), the Eighth Circuit determined that Arkansas' similar assignment statute was preempted under ERISA's express preemption clause, which provides that ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to . . . [an ERISA] plan." 29 U.S.C. § 1144(a). For several reasons, the Eighth Circuit concluded that the Arkansas law "relates to" ERISA plans and consequently was preempted. First, it found that an assignment statute directly affects the structure of ERISA plans and the relationship between the primary ERISA entities (the plan, the plan fiduciaries, and the participants) by transferring to participants the power to decide who can receive payment of ERISA benefits. 947 F.2d at 1346. Second, it determined that the state statute affected plan administration, since it changed the procedures by which plans determined how benefits should be paid and subjected multi-state plans to conflicting assignment rules. *Id.* at 1347-48. Third, the Eighth Circuit concluded that the economic impact of assignment statutes was significant, for they eliminate health care providers' incentives to enter into provider networks and diminish plans' ability to reduce costs. *Id.* at 1348-49.

The Tenth Circuit, for its part, found a similar statute to be preempted because it conflicted with the structure and provisions of ERISA itself. It "interpret[ed] ERISA as [both] leaving the assignability of benefits to the free negotiations and agreement of the contracting parties" and "insist[ing] that the states not interfere with the parties' freedom of choice." *St. Francis Regional Med. Ctr. v. Blue Cross & Blue Shield*, 49 F.3d 1460, 1464 (10th Cir. 1995).

The Fifth Circuit took direct aim at these decisions, holding that Congress's silence on the assignability of health benefits indicated congressional intent to permit states to regulate assignment issues. 461 F.3d at 540. Counter to the other circuits' decisions, it also concluded that the "burden on plan administrators [was] minimal" even for multi-state plans, because Louisiana supposedly made it easy to recognize an assignment: "Louisiana requires all insurance claims to be submitted on a uniform claim form that includes space for indicating whether benefits have been assigned." *Id.* at 539.

Nonetheless, attempting to downplay the circuit split, the Fifth Circuit suggested that this Court's decision in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995), somehow overruled the Eighth and Tenth Circuits' holdings *sub silentio*, by decrying "uncritical literalism" in applying ERISA's preemption clause. 461 F.3d at 540. But nothing about the *St. Mary's* or *St. Francis* decisions involves such "literalism." Both decisions conducted detailed analyses of the factors that this Court and lower courts have considered relevant to the "relate to" analysis under ERISA's preemption provision, including effects on plan administration, *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 9-10 (1987), and consistency with ERISA's terms and structure, *Mackey v. Lanier Collection Agency & Service*, 486 U.S. 825, 832-40 (1988). *Travelers* did not abolish those factors, and indeed this Court has continued not just to apply them but to focus on them since then in ERISA preemption cases. *See, e.g.*, *Egelhoff v. Egelhoff*, 532 U.S. 141, 147-48 (2001) (statute impermissibly "relate[s] to" ERISA "because it interferes with nationally uniform plan administration" and "runs counter" to other ERISA provisions); *UNUM Life Ins. Co. of Am. v. Ward*, 526 U.S. 358, 379 (1999) (rule "relates to" ERISA because it "would have a marked effect on plan administration"); *De Buono v.*

NYSA-ILA Med. & Clinical Servs. Fund, 520 U.S. 806, 816 (1997) (assessing effect on plan administration). Accordingly, *Travelers* did not overrule *St. Mary's* or *St. Francis* or undermine the Eighth and Tenth Circuits' reasoning, and the conflict between those decisions and the Fifth Circuit's ruling is irreconcilable.

In the same vein, the Fifth Circuit suggested that "[n]either the Eighth nor Tenth Circuits operated with the starting assumption that Congress did not intended [sic] to preempt state law in an area of traditional state regulations." 461 F.3d at 540. The Eighth and Tenth Circuits, however, acted fully in accord with the rule later articulated in *Travelers* and found that clear evidence of congressional intent to preempt the relevant field overcame any presumption to the contrary. For example, both decisions relied heavily on *Mackey*, where this Court considered the significance of congressional silence and held in that instance that such inaction favored a finding of no preemption; the Eighth and Tenth Circuits grappled with that holding but found the circumstances before them to warrant a different result than in *Mackey*. That is evidence not of some now-impermissible rush to find preemption, but of a careful cognizance that preemption was not to be assumed and certainly was in no manner automatic.

It is also significant that other courts have relied on the *St. Mary's* and *St. Francis* rulings, even after *Travelers*. *E.g.*, *City of Hope Nat'l Med. Ctr. v. Healthplus, Inc.*, 156 F.3d 223, 229 (1st Cir. 1998) ("ERISA leaves the assignability or non-assignability of health care benefits under ERISA-regulated welfare plans to the negotiations of the contracting parties."); *Bannister v. Sorenson*, 103 F.3d 632, 636 (8th Cir. 1996) (*St. Mary's* decision "sets forth an analytical structure for ERISA preemption claims that facilitates reasoned decision-making and appellate review"); *DeBartolo v. Blue Cross/Blue Shield*, 2001 U.S. Dist. LEXIS 18363, *12 (N.D. Ill. Nov. 8, 2001) (finding assignment

statute preempted); *see also Nat'l Rehabilitation Hosp. v. Manpower Int'l*, 3 F. Supp. 2d 1457, 1460 (D.D.C. 1998); *Fisher v. Building Serv. 32B-J Health Fund*, 1997 U.S. Dist. LEXIS 12886, *13 (S.D.N.Y. Aug. 27, 1997). Even the Fifth Circuit in a 2002 ruling, citing *St. Francis*, noted that "ERISA leaves the assignability of benefits to the free negotiations and agreement of the contracting parties." *Dallas County Hosp. Dist. v. Assocs.' Health & Welfare Plan*, 293 F.3d 282, 287 n.3 (5th Cir. 2002). These courts have found no inconsistency between *Travelers* and the Eighth and Tenth Circuit rulings.

The split among the circuits is particularly problematic because it raises the prospect that, until this Court sorts out the matter, plans operating in multiple states will be subject to inconsistent rules regarding assignment. State law would need to be followed in one circuit, but not in another. National uniformity in plan administration is one of ERISA's central objectives, *see infra* p. 9, adding urgency to the resolution of a circuit split on a key issue affecting plan administration.

II. THE FIFTH CIRCUIT'S DECISION CON-FLICTS WITH THIS COURT'S PRECEDENTS

A grant of certiorari would also enable this Court to reverse the Fifth Circuit's misapplication of the Court's ERISA preemption jurisprudence. The Fifth Circuit's holding cannot be reconciled with the Court's cases applying ERISA's express preemption clause, especially *Egelhoff v. Egelhoff*, 532 U.S. 141 (2001), and similar decisions. Moreover, the Fifth Circuit erroneously found the Louisiana law to escape the rule now well established in the Court's precedents that state law remedies supplementing or altering ERISA's enforcement scheme conflict with, and are preempted by, ERISA. Finally, the concurring Judge's analysis of ERISA's saving clause, whereby she rationalized the result reached in the panel's principal opinion, cannot be

squared with this Court's (and lower court) decisions on the subject.

A. The Fifth Circuit Decision Is Inconsistent with the Court's Precedents Applying ERISA's Preemption Provision

The Fifth Circuit grappled with, but ultimately misapplied, one of the Court's most recent decisions applying ERISA's preemption provision -- *Egelhoff*. The state statute at issue in *Egelhoff* revoked the designation of a spouse as the beneficiary of non-probate assets, including ERISA plan benefits, upon dissolution of marriage. The Court found that the law impermissibly bound plan administrators "to a particular choice of rules for determining beneficiary status." 532 U.S. at 147. That was improper, this Court held, because it conflicted with ERISA's statutory requirements that *the plan* "'specify the basis on which payments are made to and from the plan'" and that the plan administrator follow the "'documents and instruments governing the plan.'" *Id.* (quoting 29 U.S.C. §§ 1102(b)(4), 1104(a)(1)). Hence, the state statute "govern[ed] the payment of benefits, a central matter of plan administration," and "related to" ERISA for purposes of preemption. *Id.* at 160.

Egelhoff's holding is controlling. Just as the state statute there prohibited plan administrators from following the terms of the plan in directing payment of benefits, and required that benefits be paid to a recipient other than the plan's designee, Louisiana's assignment statute overrides the terms of ERISA plans and redirects payment to third-party providers. In other words, it imposes a "choice of rules" on plans' determinations of who is to receive payments from ERISA plans: "[t]he administrators must pay benefits to the beneficiaries chosen by state law, rather than to those identified in the plan documents." *Egelhoff*, 532 U.S. at 147.

In reaching its preemption conclusion, the Court in *Egelhoff* also paid heed to ERISA's concern for "national uniform[ity]" in plan administration. *Id.* at 148. It was impermissible in *Egelhoff* for plans to be "subject to different legal obligations in different States," such that plan administrators would have to familiarize themselves with every state's statutes to determine whether a beneficiary designation was valid. *Id.* Louisiana's law has the same defects. Absent preemption of state assignment statutes, multi-state plans would be required to consult local law in order to determine whether to honor an insured's assignment, and choice-of-law rules requiring complex analyses of what state has the greatest interest in a given transaction would simply exacerbate the problem. *Cf. Egelhoff*, 532 U.S. at 149.

The Fifth Circuit dismissed these concerns about additional burdens on multi-state plans on the ground that Louisiana had created a "uniform claim form" with an option to indicate the assignment of benefits, thereby supposedly simplifying any task of complying with an assignment regime in Louisiana that differed from other states'. 461 F.3d at 539. But that hardly solves the problem, for plan administrators must still determine whether a given assignment is valid, is subject to any conditions, or has subsequently been revoked. They must also determine whether an assignment that does actually exist is invalid if the box in question is not checked. The outcome of these determinations may differ, depending on the particular state's assignment rules.

Nor can the decision below be harmonized with *UNUM Life Insurance Co. v. Ward*, 526 U.S. 358 (1999) -- a decision the Fifth Circuit nowhere addressed. In that case, again applying ERISA's preemption provision, this Court invalidated a California rule concerning agency relationships. The rule, adopted by the California courts in *Elfstrom v. N.Y. Life Insurance Co.*, 432 P.2d 731, 737 (1967) (en banc), held

that an employer automatically "act[s] as [the] . . . agent" of an insurer who pays claims, such that notice of a claim to the employer could operate as notice to the plan's insurer. *UNUM*, 526 U.S. at 377. The rule was directly contrary to the ERISA plan's language, which provided that, "'[u]nder no circumstances will the policyholder [*i.e.*, the employer] be deemed the agent of the . . . [insurer] without a written authorization.'" *Id.* (quoting ERISA plan).

This Court had no trouble finding that "the *Elfstrom* rule 'relates to' ERISA plans." *Id.* at 379. The Court said that "deeming the policyholder-employer the agent of the insurer would have a marked effect on plan administration." *Id.* It would compel the employer "to assume a role, with attendant legal duties and consequences, that it has not undertaken voluntarily." *Id.* "[I]t would affect not merely the plan's bookkeeping obligations regarding to whom benefits checks must be sent," but would "regulate the basic services that a plan may or must provide to its participants and beneficiaries," by requiring benefits payments when the employer, as opposed to the insurer, was timely notified of a claim. *Id.* (internal quotation marks omitted).

As in *UNUM*, the state law at issue here creates involuntary legal duties relating to plan administration. *Id.* at 378. In this case, the plan has not undertaken to pay providers outside of its network directly; indeed, it has renounced exactly such a policy through the plan language itself. Furthermore, Louisiana's law would not only and obviously alter "the plan's bookkeeping obligations regarding to whom benefits checks must be sent," it would also add to those services provided by the plan, in that the plan would now be required essentially to provide collection services to out-of-network providers. *Id.* at 379. Specifically, the plan contemplates a regime whereby participants are paid for services obtained from out-of-network providers, with the providers then having to undertake their own collection efforts to obtain

reimbursement from participants. The Louisiana assignment law makes the plan the collection vehicle for the provider, compelling the plan to transmit to the provider the funds that, under the plan's terms, belong to the participant. In sum, just as a state law forcing an ERISA plan to recognize an agency relationship between an employer and an insurer was preempted in *UNUM*, a state law compelling a plan to recognize an agency relationship (via an assignment) between a provider and participant is preempted.

B. The Fifth Circuit's Decision Disregards the Court's Conflict Preemption Rulings Involving ERISA's Enforcement Mechanism

Not only is the Louisiana assignment statute preempted under ERISA's preemption provision, it fails under ordinary conflict preemption principles, because it conflicts with ERISA's exclusive enforcement scheme. The Court most recently stated the applicable rule in *Aetna Health Inc. v. Davila*, 542 U.S. 200, 209 (2004), where it declared: "any state-law cause of action that duplicates, supplements, or supplants the ERISA civil enforcement remedy conflicts with the clear congressional intent to make the ERISA remedy exclusive and is therefore pre-empted." *Accord Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 143-45 (1990); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 54-46 (1987).

The Fifth Circuit erroneously determined that the Louisiana statute was consonant with ERISA's enforcement remedy. The court of appeals said that the state law survived, because it "merely passes the sole enforcement mechanism -- ERISA § 502 -- from patient to hospital; it does not impose any additional obligation, on the ERISA plan administrator, nor does it create additional or separate means of enforcement." 461 F.3d at 535.

But the Fifth Circuit misread the governing state statute. The assignment law states:

> When any insurance company, employee benefit trust, self-insurance plan, or other entity has notice of such assignment prior to such payment [made to the insured by the company, trust, or plan] any payment to the insured shall not release that entity *from liability to the hospital* to which the benefits have been assigned, nor shall such payment be a defense to *any action by the hospital* against the entity to collect the assigned benefits.

La. Rev. Stat. Ann. § 40:2010 (2004) (emphasis added).

The state law thus envisions, in at least some circumstances, an action by the hospital against the plan to collect benefits. Unless this would be an action for benefits under ERISA's enforcement scheme (in particular, under ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B)), the assignment statute could not possibly be said to do anything other than create a remedy that "supplements" ERISA's remedial regime. *Aetna*, 542 U.S. at 209. Presumably, the Fifth Circuit believed that the hospital's remedy would be under state law, not under ERISA § 502.

And even if the Louisiana statute (and the Fifth Circuit in construing it) assumed the hospital's remedy for benefits would be under § 502, the assignment statute would fail because it establishes a damages standard not adopted in ERISA. *See UNUM*, 526 U.S. at 378 (criticizing Ninth Circuit for remanding to lower court to determine, in context of § 502 action, if "the claim was timely under *Elfstrom*"). Nowhere does ERISA articulate a damages rule that permits a party (such as the hospital) fully to collect benefits notwithstanding that another (such as the participant) has already recovered those benefits. If such a standard is to be read into ERISA, it is for federal courts applying a federal common law under ERISA to determine, not for a state legislature to mandate. *See Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 831 (2003) ("Congress 'expected'

courts would develop 'a federal common law of rights and obligations under ERISA-regulated plans'") (quoting *Pilot Life*, 481 U.S. at 56).

C. The Concurring Judge Misapplied the Court's Test Under ERISA's Saving Clause

Judge Owen's concurrence would have upheld the assignment statute on grounds that it regulates insurance and therefore comes within ERISA's saving clause, which provides that "nothing in this title shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities." 29 U.S.C. § 1144(b)(2)(A). Judge Owen, however, is mistaken, because the saving clause is inapplicable here.

As a threshold matter, it is important to note that, even if Judge Owen were correct, her analysis would not obviate the split in the circuits necessitating this Court's review. The "deemer clause" exception to the saving clause, 29 U.S.C. § 1144(b)(2)(B), exempts self-funded ERISA plans from the saving clause's "regulate insurance" analysis. This means that, to the extent a state statute "relates to" ERISA and applies to self-funded plans as opposed to insured plans, it is still preempted, whether or not the state law qualifies as a "saved" insurance regulation. *See FMC v. Holliday*, 498 U.S. 52, 61 (1990). The Louisiana assignment statute does not limit itself simply to insured plans. *See* La. Rev. Stat. Ann. § 40:2010 (including in its scope any "employee benefit trust" or "self-insurance plan"). Hence, the Fifth Circuit majority's preemption analysis would remain the law of the circuit with regard to self-funded plans even if Judge Owen's analysis were adopted as to insured plans. Since the majority's analysis is at odds with the competing Eighth and Tenth Circuit rulings, the split would remain, and Judge Owen's analysis cannot avoid the need to resolve that disagreement.

In any event, the assignment law is not a saved insurance regulation. Judge Owen cited, but then misapplied, the saving clause test enunciated by this Court in *Kentucky Association of Health Plans, Inc. v. Miller*, 538 U.S. 329 (2003). The most substantial problem with Judge Owen's analysis arises from *Miller*'s requirement that, to be considered an insurance regulation, a state law must "substantially affect the risk pooling arrangement between the insurer and the insured." *Id.* at 342. The state statute in *Miller* stated that an insured was entitled to payment for services from any provider who agreed to abide by a plan's payment terms (even if the provider was in a category otherwise excluded in the plan). In finding that law saved, the Court focused on the state statute's expansion of the plan's substantive coverage terms: "By expanding the number of providers from whom an insured may receive health services, AWP [*i.e.*, any-willing-provider] laws alter the scope of permissible bargains between insurers and insureds .... No longer may Kentucky insureds seek insurance from a closed network of health-care providers in exchange for a lower premium." *Id.* at 338-39.

The Louisiana assignment statute, by contrast, does not affect the scope of the risks accepted by the insured and the insurer. It does not address "whether or not an insurance company must cover claims" or "dictate to the insurance company the conditions under which it must pay for the risk that it has assumed." *Id.* at 339 n.3. Instead, it creates rights *for providers*. The plan is liable to a provider for failing to pay it directly, irrespective of whether the participant has received all that to which he or she is entitled under the plan. As a result, the Louisiana statute does not have "a substantial effect on the risk-pooling arrangement between *the insurer*

and insured," but on the balance of power between insurers and providers. *Id.* at 329 (emphasis added).[2]

Even if the Louisiana statute could be considered a law regulating insurance under *Miller*, it would still be preempted because, as already noted, the statute conflicts with ERISA's exclusive enforcement mechanism. This Court has noted in *Aetna* and elsewhere that ERISA's civil enforcement provision represents an "overpowering federal policy" that trumps even the saving clause: "even a state law that can arguably be characterized as 'regulating insurance' will be pre-empted if it provides a separate vehicle to assert a claim for benefits outside of, or in addition to, ERISA's remedial scheme." 542 U.S. at 217.

III. THE FIFTH CIRCUIT'S DECISION HAS FAR-REACHING PRACTICAL IMPLICATIONS

Important practical considerations strongly favor a grant of certiorari in this case. Many of the most common models for employer-based health insurance rely heavily on delicate and intricately negotiated relationships between plans and providers. Louisiana's assignment statute disrupts those relationships, with potentially profound consequences for the nation's health care system. In particular, the statute threatens the predominant health benefits arrangement currently adopted by ERISA plans: preferred provider organizations, or "PPOs."

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[2] Consistent with this conclusion, many lower courts since *Miller* have found that state statutes do not affect the risk pooling relationship if they do not directly affect the bargain between the insurer and insured, and these courts have so held even if the state laws focus on the rights for insureds as opposed to third parties. *E.g.*, *Barber v. UNUM Life Ins. Co. of Am.*, 383 F.3d 134, 143 (3d Cir. 2004); *Provident Life & Accident Ins. Co. v. Sharpless*, 364 F.3d 634, 641 (5th Cir. 2004); *Allison v. UNUM Life Ins. Co.*, 381 F.3d 1015, 1027 (10th Cir. 2004); *Kidneigh v. UNUM Life Ins. Co.*, 345 F.3d 1182, 1187 (10th Cir. 2003). Of course, the Louisiana law is more problematic than even these state laws because it does not focus on rights for insureds, but for providers who are not in any facet part of the risk-pooling bargain.

Over the past thirty years, the private sector has seen many changes to the health insurance environment. In Congress's view, traditional indemnity plans, which imposed no restrictions on a patient's choice of providers, did not meaningfully restrain costs. *See, e.g.*, S. Rep. No. 93-129, 3045, 3047 (1973). Therefore, starting in the 1970s, Congress encouraged the formation of health maintenance organizations ("HMOs"), whose hallmark is care provided by a closed panel of providers subject to strict "procedures to monitor utilization and control cost of basic and supplemental health services." 42 C.F.R. § 417.103(b) (implementing the Health Maintenance Organization Act of 1973, 42 U.S.C. § 300e(c)(2)(D)). Many employers adopted HMOs in the 1980s, but the perception arose that the HMO model unduly limited patients' choice of providers. *See* "As Employers Look to Hang on to Workers, PPOs Gain Favor," Business First (Dec. 8, 2000).

In response, the employer-based market has since then developed a wide variety of health insurance options. Employers can now choose between traditional indemnity plans, HMOs, PPOs, point-of-service ("POS") plans, and numerous variants and combinations of these approaches. While offering greater patient freedom as to choice of providers, these plans are designed to encourage participants to use in-network providers who agree to discounted rates and other cost constraints. For example, PPOs utilize: (1) a "network of health care providers who have agreed to provide care to the PPO's patients, subject to contractually established reimbursement levels"; (2) incentives for patients to obtain services from the in-network providers; and (3) "repricing" features under which plans apply negotiated discounts to the in-network providers' claims. American Association of Preferred Provider Organizations, *PPO 101: A Comprehensive Overview of the PPO Industry* 30, 33, 35-36 (2005) [hereinafter "*PPO 101*"].

Other health plan models rely on in- and out-of-network distinctions as well. POS plans are a variation on HMOs that permit enrollees to seek care outside the HMO provider system, but impose higher deductibles and higher coinsurance. *See* Peter R. Kongsvedt, *Managed Care: What It Is And How it Works* 49 (2004). Likewise, traditional service plans arrange for a network of providers, with fewer restrictions than PPOs impose, creating a discount for services within the network. *Id.* at 40-41.

The beneficial effect of these health insurance arrangements on spiraling health care expenditures is now well-recognized. Commentators have noted that PPOs and similar products offer consumer choice while "address[ing] the issue of increasing hospital costs." Adrian Bull, "Let's Take the Market Forward," Financial Adviser, June 5, 2003; *accord* "As Employers Look to Hang on to Workers, PPOs Gain Favor," *supra*; "Managed Care Shifts Direction," Employee Benefit Plan Review (Feb. 2000); Lisa A. Krouse, "Managed Care and Workers' Compensation," 33 Tort & Ins. L.J. 849 (Spring 1998); Nancy Bader, "Retaining Freedom of Choice in a Managed Care Plan," Business & Health (Oct. 1993). Courts likewise have said it is "easy to see how health costs might be constrained" by the PPO model. *Washington Hosp. Ctr.*, 758 F. Supp. at 754; *accord Renfrew Ctr. v. Blue Cross & Blue Shield of Central N.Y., Inc.*, 1997 U.S. Dist. LEXIS 5088, at *9-*10 (N.D.N.Y. Apr. 10, 1997).

Assignment laws like Louisiana's jeopardize the viability of PPOs, POS plans, and other products that rely on network arrangements. A central incentive under these models for a provider to join the network and thereby agree to the discounted "reimbursement schedule and any other cost constraints" is the promise of "rapid, certain and direct payments from the insurer." *Washington Hosp. Ctr. Corp. v. Group Hosp. & Med. Servs., Inc.*, 758 F. Supp. 750, 754 (D.D.C. 1991). Louisiana's assignment law takes away that

incentive. Whereas an out-of-network provider would customarily need to turn to the patient (and the patient would receive direct payment from the plan) to collect for his or her services, Louisiana's law awards that provider the benefit of being in the network -- direct payment from the plan -- without requiring it to accept any of the obligations of in-network status (such as negotiated rates or other cost-containment measures). Consequently, under the assignment statute, providers have little if any incentive to join such networks. Were the Fifth Circuit's decision authorizing the application of laws like Louisiana's in the ERISA context allowed to stand, these network arrangements would be at risk.

Because it so seriously threatens the viability of products reliant on network arrangements, the Fifth Circuit's decision has momentous implications for the future of employer-based health insurance. The PPO has met with great success in the employer market, in no small measure because it has proven to be such a vital tool in the employers' struggle to hold down health care expenditures. The PPO is now the most prevalent health benefits offering in the United States, accounting for 61% of all individuals with employer-provided health insurance. *PPO 101*, at 6. The preemption question raised in this case thus affects the principal form of ERISA health benefits arrangement, one adopted because of its salutary effect on the difficult issue of containing health care costs.

Participants in ERISA plans will also be worse off if the Fifth Circuit's decision is permitted to stand. When creating their networks, health insurers can and do screen providers to ensure that members will receive high-quality care (*see PPO 101* at 35-36); destroying preferred provider arrangements necessarily means the loss of those credentialing and quality-assurance mechanisms beneficial to plans and participants alike. Moreover, providers are often required to "agree[] to accept payment by Blue Cross as full payment without

billing the patient for any balance" as a condition for participation in the network. *Washington Hosp. Ctr.*, 758 F. Supp. at 754. Participants benefit from these types of plans because "the insurer will pay for the entire cost of covered services (apart from any initial deductibles) instead of the lesser reimbursement available for use of non-participating hospitals." *Id.* Finally, the discounted rates for use of in-network provider (in plans that rely on the distinction between in- and-out-of-network providers) benefit both plans *and* participants.

In sum, the damage that the Fifth Circuit's decision portends for ERISA health benefits arrangements and to participant interests supports the granting of the Petition.

CONCLUSION

The Petition for a Writ of Certiorari should be granted.

Respectfully submitted,

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